

Patient Registration Form
Duchon Chiropractic
2724 61st #5
Galveston, Texas 77551
Office: 409-744-9355 • Fax: 409-744-9356

Patient Name: _____
Last First Middle

Address: _____
Street City State Zip Code

Home: () _____ Work: () _____ Cell: () _____

S.S.N.: _____ Date of Birth: _____ Age: _____

Gender: Male Female Email Address: _____

Marital Status: Married Divorced Single Widowed

Referring Physician: _____ Reason for your visit? _____

Phone: () _____

Address: _____
Street City State Zip Code

Employer or School: _____ Address: _____

Emergency Contact: _____ Relation: _____ Phone: () _____

Spouse's Name: _____ S.S.N.: _____

Spouse's Date of Birth: _____ Employer: _____

Spouse's Phone: () _____ Are you insured under their policy? Yes No

Responsible Party Name and Address (Under 18):

Relation to Patient: _____

Date of Birth: _____ Employer: _____ Phone: () _____

Health/Medical Insurance Yes No Self-Pay

PATIENT INSURANCE INFORMATION TO BE COMPLETED ON PATIENT INSURANCE FORM ATTACHED

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE.

Signature: _____ **Date:** _____

Patient Name: _____ DOB: _____

Primary Insurance Information:

Insurance Name: _____ Effective Date: _____

Subscriber/ID#: _____ Group # _____

Claims Address: _____

Phone Number: _____ Copay: _____

Primary Insured: (circle one) Self Spouse

Employer: _____

Date of Birth: _____ Social Security Number: _____

Secondary Insurance Information:

Insurance Name: _____ Effective Date: _____

Subscriber/ID#: _____ Group # _____

Claims Address: _____

Phone Number: _____ Copay: _____

Primary Insured: (circle one) Self Spouse

Employer: _____

Date of Birth: _____ Social Security Number: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request the payment of the authorized Medicare/other Insurance Company benefits be made to me or on my behalf to Duchon Chiropractic for any services furnished to me by that party who accepts assignments/medical professional. Regulations pertaining to Medicare assignment benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carries any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying my treatment. (Section 1128B of the Social Security Act & 31 U.S.C. 3801-3812 provides penalties for withholding this information).

Signature: _____ **Date:** _____

Duchon Chiropractic

Insurance & Financial Policy

Welcome to our practice. We are committed to providing you with the best possible care by offering you treatment options that may or may not be covered by your insurance. We are open to discussing these options with you at any time.

Currently we are participating with many major insurance companies. Insurance is a contract between you and your insurance company. It is your responsibility to be aware of your benefits. If you are unsure of your insurance benefits, you will need to contact your insurance carrier for clarification of your benefits. Certain services may or may not be covered by Medicare or Medicaid and it is the patient's responsibility to inquire as to the eligibility of a treatment for Medicare or Medicaid coverage.

This office bills your insurance for services performed by our providers. The laboratory will bill you or your insurance company of all labs performed. If you have question regarding your lab bill, please contact the laboratory directly or your insurance carrier.

Please bring your insurance card to each appointment. If you change insurance companies or benefits, you must call our office with the new information at least 48 hours prior to your appointment. If you do not, you will be responsible for the bill.

All insurance information, including referrals, and claim forms when necessary must be provided at the time of services. Please be sure to check that referral from your primary care physician has been received two (2) days prior to your appointment. We cannot see you without a valid referral if a referral is required by your insurance company. It is your responsibility to ensure that a referral has been created through your Primary Care Physician's office when required by your insurance. Balances for any reason, co-pay, deductible, coinsurance and denials for any reason are the responsibility of the patient or guarantor.

All co-pays, deductibles, and payments are due at the time of service, with co-pays being collected prior to you seeing the doctor. When receiving a statement after your visit, payment is due immediately upon receipt. To better accommodate your needs, we accept cash, personal checks, debit cards, Visa and Mastercard as forms of payment. Any personal checks returned to us from you bank will be subject to a fee of \$40.00.

We will assign all accounts thirty (30) days or more past due to an outside collection agency for assistance. This may be an automatic assignment unless prior arrangements have been approved by management. Should this step be necessary, we may add a \$45.00 service charge to your balance. Any collection fees necessary to collect this debt will be added to the outstanding balance. Please keep in mind that should your account go to our collection agency, any arrangements/payments will need to be made directly to the collection agency. In addition, once an account has been turned over to the collection agency, the patient will receive a letter of discharge from our practice.

We understand that situations may arise that require you to cancel your appointment; however we do request a 24 business hour notice of such cancellation. We may charge a \$50.00 fee for any appointments that have not been cancelled within this timeframe.

An administrative fee of \$75.00 per form will be charged for any forms (relating to disability, auto injury, life insurance applications, motor vehicle division, employment matter, etc.) that need to be reviewed and/or filled out by our medical professionals. All administrative fees must be prepaid.

Please keep all copies of all patient receipts. Should you need an end of year statement for tax purposes, an administrative fee of \$25.00 will apply.

Any patient who commits any of the following offenses, including but not limited to: abusive behavior, non-compliance with treatment, Rx misuse, multiple missed office visits, or failure to pay account shall be grounds for immediate dismissal from the practice.

Thank you for understanding our financial and insurance policies. If you have questions about the above information, please do not hesitate to ask us. We are here to assist you.

I have read the above Insurance & Financial Policy, and understand and agree to these terms.

Printed Patient Name: _____

Patient Signature: _____

Date: _____

Duchon Chiropractic
Protected Health Information

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual also has the right to request that communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

HOME TELEPHONE () _____

- O.K. to leave message with detailed information
- Leave message with call-back number only
- O.K. to fax to: () _____

WORK TELEPHONE () _____

- O.K. to leave message with detailed information Use other:
- Leave message with call-back number only

WRITTEN COMMUNICATION

- O.K. to mail to my home address on file Use other:
- O.K. to mail to my work address

Email

O.K. to email detailed information to the following email address:

Patient Signature

Date

Print Name

S.S.N.

The Privacy Rule generally requires health care providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum information necessary to accomplish the intended purpose. These provisions do not apply to the uses or disclosures made pursuant to an authorization requested by the individual.

Disclosure of treatment records, payment information, and healthcare operations may be permitted without prior written consent in an emergency.

Duchon Chiropractic
Authorization for Release of Information

Patient Name: _____ DOB: ___/___/___ SSN: ____-____-____

Address: _____

Home Phone: () _____ Cell Phone: () _____

I authorize: _____

| | | |
|------------------|---------------|----------------|
| Physician Name | Facility Name | Facility Phone |
| _____ | | |
| Facility Address | Facility Fax | |
| _____ | | |

To send/release photocopies of medical records concerning the above named person to:

Duchon Chiropractic
2724 61st #5
Galveston, Texas 77551

For the purpose of treatment for _____. I authorize the release of photocopies of the following medical records and information in their possession including all confidential HIV related information, confidential alcohol or drug abuse related information and confidential mental health diagnosis and treatment information. I agree that these provisions will remain in effect until I provide written revocation to Duchon Chiropractic.

- Medical Records Hospital Records Procedure Records Laboratory Records
- _____ Inpatient _____ Outpatient Other

| | | |
|--|--------------------------------|-------------|
| _____ | _____ | _____ |
| Signature of Patient/Legal Guardian | Relationship to Patient | Date |

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse and HIV or communicable disease) requested by my health insurance carrier, Medicare or any other third-party payers, and I authorize Duchon Chiropractic to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Duchon Chiropractic.

I agree that these provisions will remain in effect until I provide written revocation to Duchon Chiropractic.

| | | |
|--|--------------------------------|-------------|
| _____ | _____ | _____ |
| Signature of Patient/Legal Guardian | Relationship to Patient | Date |

Duchon Chiropractic
Patient Consent Form

I, _____, understand that as part of my health care, that Duchon Chiropractic creates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I acknowledge that I have been provided with a *Notice of Privacy* which provides a more complete description of information uses and disclosures.

I understand that Duchon Chiropractic is not required to agree to the restrictions requested and that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Federal and State Regulations.

I further understand that Duchon Chiropractic reserves the right to change their notice and practices and prior to implementation, in accordance with Federal and State Regulations.

Duchon Chiropractic has my consent to give out my private health information, including my identity, diagnoses and treatments, whether in writing or verbally, to the following persons or entities (e.g. spouse, child or other representative):

Name Relationship to Patient

Name Relationship to Patient

Name Relationship to Patient

I understand that as require for Duchon Chiropractic's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

Patient or Guardian

Witness

Date

Date

Duchon Chiropractic

2724 61st #5

Galveston, Texas 77551

Office: 409-744-9355 • Fax: 409-744-9356

CONSENT TO CHIROPRACTIC SERVICES

I, _____, authorize the performance upon

(Patient's Name)

myself of the following procedure(s): Exam and necessary x-rays; and

(State nature and extent of diagnostic/therapeutic services)

to be performed by or under the direction of Dr. Chad Duchon.

I also consent to the performance of other diagnostic and therapeutic procedures in addition to or different from those stated above that Dr. Duchon, his associate, or his assistant, considers necessary or advisable in the course of my treatment, whether or not arising from presently unforeseen conditions.

The nature and purpose of the procedures, possible alternatives, the risks involved, the possible consequences, and the possibility of complications have been explained to me by Dr. Duchon and/or his associate or assistant.

I acknowledge that no guarantee or assurance as to the results that may be obtained from the procedure has been given by Dr. Duchon, his associate, or his assistant.

Date: _____

Signature: _____

Witness: _____ Relationship: _____

Health History

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

- | | | | | |
|--|--|---|--|-------------------------------------|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Sudden Weight Loss | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Arm/Hand Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Leg/Knee Pain | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension | <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Shortness of Breath | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Bowel/Bladder Changes | |

Please check to indicate if you have ever had any of the following:

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures | <input type="checkbox"/> Measles | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraines | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | |
| | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other _____ | |

Are you currently under drug and/or medical care? Yes No If yes, explain _____

Please list any medications you are currently taking (**Be sure to include dosage and frequency**) _____

Please list any surgeries and/or hospitalizations you have had (**type & date**): _____

Please list any allergies: _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (**Indicate family member including parents, grandparents & siblings**)

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Arthritis _____ | |

Do you exercise: Never Daily Weekly Walks Runs Swims

Do your work activities mostly involve: Sitting Standing Light Labor Heavy Labor

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ **DATE** _____

Reviewed by Provider: _____ (initials)

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X-ray Questionnaire: For Women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-ray be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

There is a possibility that I may be pregnant at this time.

Yes, I am definitely pregnant

No, I am definitely not pregnant at this time

I request that x-ray films not be taken because: _____

Date of last menstrual period: _____

Patient's Signature

Date