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: _____

Galveston Physical Medicine

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:

Galveston Physical Medicine
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 Galveston Physical Medicine.

☐ Medical Records ☐ Hospital Records ☐ Procedure Records ☐ Laboratory Records

_____ Inpatient _____ Outpatient ☐ Other

_____ _____ _____

Signature of Patient/Legal Guardian Relationship to Patient Date

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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 Galveston Physical Medicine 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 Galveston Physical Medicine.

I agree that these provisions will remain in effect until I provide written revocation to Galveston Physical Medicine.

_____ _____ _____

Signature of Patient/Legal Guardian Relationship to Patient Date

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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: _____

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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:

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

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

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

❑ Heart Disease _____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

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