-10Insight Chiropractic
New Patient Information

Welcome to Insight Chiropractic!! You have chosen a great office for your chiropractic care!

New Patient Introduction forms maybe filled out on-line in this PDF format or printed and filled out by hand. Please read and answer the forms thoroughly before you come into the office. The better the history you can provide the better the doctor can understand your condition(s.) If you need, please write on the back of the forms to explain anything further. Please have your paperwork filled out before your first visit, this will ensure more time with the doctor and limit the possibility of returning for another visit because the examination was not completed in the allotted appointment time.

If you have insurance, please bring your insurance card and your photo ID;so we can photo copy it and begin your insurance verification process. If you are comfortable you may fax a copy of the front and back of your insurance card plus your photo ID card to 408-371-2046. Please note, our fax machine is in a secure location in our office.

Everyone starts as cash patients and then transfers over to other designated patient types (insurance, personal injury, worker's compensation, medicare) once verification has been determined. Please bring a form of payment for this first visit. If your insurance covers the first visit, then a credit will be placed on your account and future "co-pays/patient portions" will be deducted from the credit balance until the balance is zero.

Please dress in loose fitting sports clothes and expect to be at the office for your first visit at least 1 hour. The doctor will perform a detail history and examination during this time.

A chiropractic treatment is generally provided on the first visit, but on occasion, based on your history and condition, x-rays or a medical consultation may be necessary before a chiropractic treatment is given. The doctor will alert you when certain circumstance arise and request an x-ray or medical consultation before treating. X-rays or medical consultations help to provide better tools for diagnosis when the need arises.

Our address: 1860 S. Bascom Ave. Ste 101 Campbell CA 95008
Phone#: 408-371-2042
Our Fax#: 408-371-2046

We are located in Campbell across the street from the Pruneyard on Bascom Ave. Our neighboring buildings are Rasputin Music and Pool Patio and More. Insight Chiropractic is located in a two-story brick building and we are located on the first floor and the first door on the right (Suite 101). Please visit the **Contact Us tab** on the website for driving directions or to email.

Yours in Health,
Dr. Jennifer L. Forster

INTRODUCTION FORM

Today's Date: ________________________ Account #_________________

Last Name:	**MI:** **First Name:**
Home Address:	City: State: Zip:
Home Phone: ( )	Cell Phone: ( )
Email:	
Birth Date: Age:	Social Security Number:
Height: Weight:	Marital Status (Circle): Single, Married, Divorced, Widow
Employer's Name:	**Occupation:**
Employer's Address:	City: State: Zip:
Work Phone:	Email:
Who Referred You to Our Office:	
Name and # of Family Physician:	
Emergency Contact: (Name, Relationship, Phone#)	

PLEASE READ:

☐ **YES,** ☐ **NO I authorize the following telephone numbers:**
☐ **YES,** ☐ **NO I authorize the use of my name/address**

Federal/State HIPAA patient privacy laws allow you to restrict doctor/staff communication with you or to contact you through alternative means. We need your permission to contact you via telephone at your work or home, cellular telephone, or to leave messages on your answering machine. Your agreement will allow our office to use your name and mailing address for sending reminders about scheduled appointments, re-activation letters, sending birthday/holiday cards, office newsletters, or providing information about other health related matters that may be of interest to you, billing statements/questions, status of your account, and other office related matters. If you have a telephone number that you do not want used for messages or calls to, please avoid writing these numbers down. You may indicate a preferred mailing address by indicating so on this form. This authorization may be revoked by you at any time, by advising our office (Privacy Officer) of this revocation in writing. If you choose not to sign this authorization, this will not have any adverse effect on your treatment, eligibility for benefits, enrollment, or payment.

IS THIS VISIT RELATED TO A:

☐ Work Related Injury/Symptoms	☐ Motorcycle-Bicycle Injury	☐ Non-Injury Pain/Symptoms
☐ Sport or Recreational Injury	☐ Home Injury Symptoms	☐ Check-up Only
☐ Motor Vehicle Crash Injury	☐ School/Employment Physical	☐ Other (Describe):

HEALTH-MEDICAL INSURANCE INFORMATION

Does your insurance plan cover Chiropractic treatment?	☐ Yes ☐ No ☐ Not Sure?
If yes, indicate Insurance Company Name (Need copy of card). Name: COPIED: Y N	Insurance Name: ________________________________ Telephone: ____________________________________
Are you the insured person or dependent (wife/husband/child)?	☐ Insured ☐ Dependent
If you are the insured person's dependent (spouse or child), we need the insured person's name, date of birth, social security number, and the name of the insured employers business in order to do billing.	Name of Insured Person: ___________________________ Social Security Number: ___________________________ Insured Date of Birth: ____________________________ Name of Insured Employer:________________________

OUR OFFICE WILL PROVIDE INSURANCE BILLING SERVICES AS A COURTESY. HOWEVER, IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE EXPECT PAYMENT AT THE CONCLUSION OF EACH TREATMENT FOR CASH PATIENTS AND THE CO-PAYMENT AND/OR DEDUCTIBLE FOR REGULAR HEALTH INSURANCE PATIENTS.

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine and extremities, as he or she deems appropriate. The Doctor will not be held responsible for any pre-existing medically diagnosed condition nor for any medical diagnosis. Additionally, I am a responsible party and agree to pay for any outstanding bills incurred in this office. It is my responsibility to pay any deductible, co-insurance, and/or any other balances not paid by my health insurance carrier. Minors must have parent's signature.

Patient Signature:____ Date:______________

If Minor, Parent Signature: ____ Date:______________

Financial Responsibility Appointment Acknowledgment

CASH

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable.

INSURANCE

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I comprehend that benefits and eligibility of my insurance is not a guarantee of coverage or payment. Insurance payment is based on actual terms and condition of my insurance plan. Additionally, it is my responsibility to pay any deductible, co-insurance, and/or any other balances not paid by my health insurance carrier.

I have read and understand my Financial Responsibility: ____________
Initials

Cancellation and "No Show" Policy

Cancellations: Please inform the office as soon as possible if you need to cancel or change your scheduled appointment, so that we may schedule other patients in the time slot that was set a side for you. We appreciate cancellations 24 hours prior to your scheduled appointment time. **Please note that cancellations or "no show" appointments with less than two hours notice will result in a charge of $25-$45 to your account and cannot be billed to your insurance company.** More than three cancellations or "no show" appointments may result in the termination of our medical relationship. Appointment times are specially designated for the chiropractor and for each chiropractic need such as: new patient visit; re-exams visits; adjustments and special needs. All these appointment are scheduled at specific times during the day, so your cancellation does affect our daily schedule. We must know in advance if you plan on a cancellation.

I have read and understand the Cancellation and "No Show" Policy: _________
Initials

Patient Acknowledgment of HIPPA Privacy Practices

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much you acknowledging your receipt of our policy by signing and returning this document. We look forward to seeing you again.

I have Received and Read the laminated copies of the:___________
HIPAA privacy practices Patient Rights Initials

"Signature On File"

Provider: Jennifer L. Forster, D.C.

- I authorize "The Provider" to use the "Signature on File" on all future billings on the CMS 1500 forms
- I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
- I authorize payment of medical benefits to "The Provider" for services or supplies described below.
- I authorize a copy of this form serve as an original.

Print Patient Name:____

Signature of Patient:______________________________Date:______________

Insight Chiropractic's Financial Policy (Pg 1)

This is an agreement between Dr. Jennifer L. Forster, D.C., as creditor, and the Patient/Debtor named on this form.

NAME: ____

In this agreement the words, "you," "your," and "yours," mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Dr. Jennifer L. Forster, D.C.

By executing this agreement, you are agreeing to pay for all services that are received.

Payment options if you have no insurance:

1. You choose to pay by _____cash, _____check, or ____credit card on the day that treatment is rendered.
2. On extensive treatment, you may prefer to secure a bank, credit union, or other third-party financing for the entire amount and make payments to the lending institution.

Payment options if you have insurance:

1. You choose to pay your deductible $________ and any out-of-pocket portions at the time services are rendered by ____cash, ____check, or ____credit card. Additionally, the insurance carrier will send the remaining payment to the healthcare provider.
2. You choose to pay all of your treatment by _____cash, _____check, or ____credit card. We will request your insurance carrier send their payment directly to you. Otherwise, we will estimate your patient portion
3. All insurance checks and payments will be assigned to our office. If you mistakenly receive an insurance check in your mail, please bring the check and all attached paperwork to our office so that we may properly credit your account.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. **You agree to pay any portion of the charges not covered by insurance.** If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company and you may be responsible for your entire account.

Non-contracted insurance: Insurance is a contract between you and your insurance company. We are NOT a party in this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although, we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. **You agree to pay any portion of the charges not covered by insurance.** If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company and you may be responsible for your entire account.

Monthly Statements: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payments: Unless we approve other arrangements in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Finance Charge: **A finance charge will be imposed on each item of your account that has not been paid within thirty (30) days of the time the item was added to the account.** The FINANCE CHARGE will be computed at the rate of one percent (1%) per month or an ANNUAL PERCENTAGE RATE of twelve (12%) percent or highest legal amount by law . The finance charge on your account is computed by applying the periodic rate (1%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time.

Insight Chiropractic's Financial Policy (Pg 2)

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collections costs that are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Santa Clara County, California.

Returned checks: **<u>There is a fee of twenty-five ($25) dollars for any checks returned by the bank.</u>**

Missed appointment fee: The second time a patient does not show up on time for an appointment, or cancels with less than 24 hours notice a $25 cancellation fee or a $45 no show fee will be charged to your account and **<u>cannot be billed to your insurance company</u>**. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments will be asked to transfer their records to another doctor.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Transferring of Records: You will need to request in writing 10 days in advance, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is report to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Worker's Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, your case shall be closed and transferred to a provider with the authorization to treat you. **<u>Additionally, you may be responsible for payment in full of all services rendered to date.</u>**

Personal Injury: If you are being treated as a part of a personal injury lawsuit or claim, we require verification from your attorney and/or insurance company prior to your initial visit. In addition to this verification, we require that you allow us to bill your health and/or personal insurance (MEDPAY.) In the absence of insurance, other financial arrangements may be discussed. **<u>Payment of the bill remains the patient's responsibility.</u>** We cannot bill your attorney for charges incurred due to a personal injury case.

Co-Signature: If this or another Financial Policy is sign by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name: ______________________________

Responsible Party (if not patient): ______________________________

Signature: ______________________ Date: ______________

Co-Signature: ______________________ Date: ______________

GENERAL HEALTH HISTORY

Patient Name:______________________________**File#**________________________**Date:**____________

Circle only those conditions that apply to you and write if you have had in the past or presently have. Additionally, indicate conditions that your parents or grandparents have had.

Bruise easily
Heal Slowly
Body Temperature (Feels Cold)
Body Temperature (Feels Hot)
Smoke Cigarettes
Chew Tobacco
Diabetes
Hypoglycemia
Thyroid disorder
Kidney disease
Liver disease
Heart Attack
Heart Pacemaker
Neck or Chest Shunts
AIDS or STDs
Tuberculosis
Dizziness
Blackouts
Balance Problems
Fainting
Tripping
Osteoporosis or Osteopenia
Gout of your spine or joints
Headaches/Migranies

Allergies
Allergies to Lotions/Tapes
Epilepsy-Seizure-Convulsion
Other Muscular/Neurological Disease
Multiple Sclerosis
Lupus
Psoriasis
Temporary Paralysis
Meningitis
Cancer or Cancer Treatment
Scoliosis
Spondylolisthesis
Spina Bifida
Fused Vertebrae
Bulging or Herniated disc
Disc Degeneration
Blood Clots
Bleeding or Vascular Disorder
Abdominal Aneurysm
Hypertension or High Blood Pressure
Ankylosing Spondylitis
Osteoarthritis/Rheumatoid Arthritis
Psychiatric/Bipolar/Depression disorder
Other:

WOMEN ONLY:	Do you currently have any type of breast implants?	Y	N
WOMEN ONLY:	Is there any chance that you are currently pregnant?	Y	N

PRIOR INJURY OR MUSCULOSKELETAL PAIN HISTORY

(**☐ I have no history of previous painful injury or pain**) If you have had prior injuries or pain, please check below:

☐ Work Injury	☐ Fall	☐ Sports Injury	☐ Lifting Injury	☐ Car accident
☐ Motorcycle Injury	☐ Head Injury	☐ Pedestrian Injury	☐ Military Injury	☐ Other Injury
☐ Headaches/Migraines	☐ Neck Pain/Arm Pain	☐ Middle Back Pain	☐ Low Back/Leg Pain	☐ Other Pain

FRACTURES/BROKEN BONES

(**☐ I have never had any broken bones).** If you have broken any bones, indicate where and when below:

Region	Year	Region	Year
☐ Spinal Vertebra		☐ Skull	
☐ Collar bone (clavicle)		☐ Rib bone	
☐ Arm or hand bone		☐ Leg or foot bone	
☐ Pelvis or hip bones		☐ Other	

PREVIOUS SURGERIES

(**☐ I have never had any surgical procedure).** If you have had any previous surgery, indicate type and when:

Surgery	Year	Surgery	Year
☐ Spine Surgery (neck, back, or pelvis)		☐ Appendix	
☐ Disc surgery in neck or back		☐ Gallbladder/Stomach/Kidney	
☐ Heart		☐ Cancer (any type)	
☐ Tonsillectomy		☐ Rib/Collar bone	
☐ Head/Brain		☐ Hernia	
☐ Shoulder/Arm/Hip/Leg		☐ Other	

GENERAL HEALTH HISTORY (Page 2)

Patient Name:______________________________**File#**________________________**Date:**____________

LIST ALL SYMPTOM REGIONS AND HOW LONG YOU HAVE HAD THEM

CHECK ALL SYMPTOM AREAS	HOW LONG	CHECK ALL SYMPTOM AREAS	HOW LONG
☐ Headaches/Migraines		☐ Hip Pain	
☐ Neck Pain, Soreness, or Stiffness		☐ Arm/Hand Pain, Numbness, or Tingling	
☐ Upper/Mid Back Pain, Soreness, or Stiffness		☐ Leg / Foot Pain, Numbness, or Tingling	
☐ Low Back Pain, Soreness, or Stiffness		☐ Other:	

Have you seen another health care practitioner for your recent complaint? ☐ No ☐Yes______________

Did your symptoms come on? ☐ Suddenly, ☐ Gradually

Are your symptoms getting consistently worse as time goes on? ☐ No ☐ Yes__________________________

SYMPTOM/PAIN DESCRIPTION

Please circle any word or all words below that best describes how your symptoms currently feel to you.

Pain or soreness	Pinching	Spreading	Vicious	Unbearable
Ache	Pricking	Shooting	Sickening	Swelling
Cutting	Tingling	Stabbing	Miserable	Pins and Needles
Tearing	Gnawing	Dull	Troublesome	Radiating
Crushing	Nagging	Bony	Pressing	Weakness
Pulling	Boring	Terrifying	Deep pain	Falls asleep
Irritating	Burning-Hot	Dreadful	Superficial pain	Suffocating
Annoying	Drill like	Fearful	Stinging	Punishing
Stiff or tight	Heavy	Unhappy	Throbbing	Crawling
Exhausting	Numbness	Torturing	Sharp	Tender

Have you ever been to a Chiropractor before for any condition?

☐ No, ☐ Yes If yes, Chiropractor's Name : ___________________________________Year:____________

Problem seen for: ____

☐ No, ☐ Yes Do you have any problems laying face down on an examination table? If yes, why: __________

ARE YOU TAKING ANY MEDICATIONS?

☐ **I am not taking any medications currently.** Check any of the following that you are taking currently.

	Muscle Relaxants		Blood pressure/Stroke prevention medications		Cortisone injections
	Pain/Anti-inflammatory meds		Osteoporosis (bone strengthening) medications		Other:

WHEN IS PAIN WORSE & WHAT ACTIVITIES INCREASE YOUR PAIN LEVELS?

	Morning pain is worse		Bending your back increases pain		Walking increases pain
	Afternoon/evening pain worse		Lying down flat increases pain		Standing increases pain
	During sleep hours pain worse		Sitting increases pain		Exercise/Stretching increases pain
	Standing up from sitting		Poor posture increases pain		Other:

HAS YOUR PAIN BEEN ASSOCIATED WITH ANY OF THE FOLLOWING?

	Excessive fatigue-malaise		Bowel or bladder disorders		Night pain or night time sweats
	Weight loss		Ovarian pain		Abdominal pain
	Low grade fever		Kidney pain/painful urination		Balance problems

EXERCISE AND DIET?

	I do not regularly exercise		I do weight lifting at gym/home		I do regular sports activities
	I stretch regularly		I am not willing to do exercises		I eat / like fresh fruits & vegetables
	I am willing to do exercise		I exercise 3-5 times a week		I eat/like processed foods (fried/packaged)
	I exercise 1-2 times a week		I do cardiovascular work outs		I eat / like sugary foods or drinks

Patient Name: File#: Date:

Exam #: First

Patient's Subjective Notes

Patient, please complete the following questions regarding how you feel today.

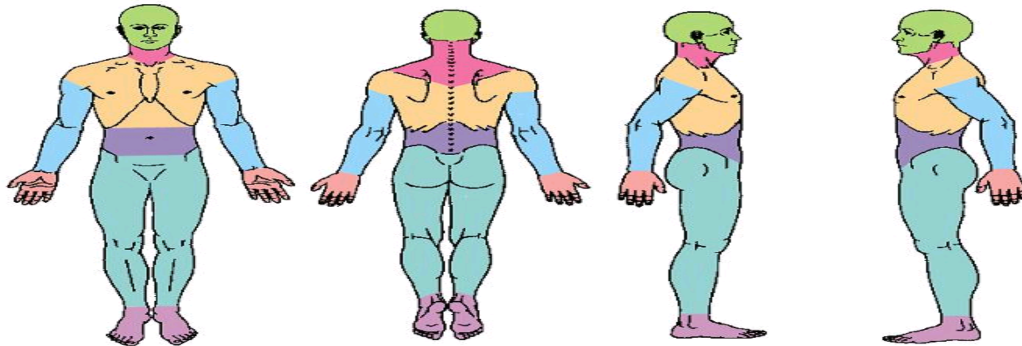
1. How do you feel today? (Current Complaints/Conditions)

____

____

2. Mark the location of your pain and write next to it the description of the discomfort you're experiencing.

SHARP & STABBING DULL & ACHY PINS & NEEDLES DEEP LOCKED UP
NUMBNESS TIGHT SPASM BURNING LIMITED Range of Motion



3. What makes your complaint feel **WORST**?________________________
4. What makes your complaint feel **BETTER**?________________________
5. Rate your discomfort level: 0 to 10 (0=No Pain 10=Unbearable Pain):
   TODAY_______/10 **YESTERDAY**_________/10 **Weekly Average**:_________/10
5. What percentage of the **DAY** do you experience your discomfort?
   Minimal 10-30% 0ccasional 40-60% Frequent 70-90% Constant 90-100%
6. What percentage of the **WEEK** do you experience your discomfort?
   Minimal 10-30% 0ccasional 40-60% Frequent 70-90% Constant 90-100%
6. Describe any internal symptoms you may be experiencing (ie-heartburn, stomachs, PMS, headaches)

____

Please circle the appropriate # to describe your present pain level in each specific region.

Area of Pain	Normal	Mildly in pain	Moderate pain	Severe Pain
Headaches	0 1	2 3 4	5 6 7	8 9 10
Neck	0 1	2 3 4	5 6 7	8 9 10
Middle back	0 1	2 3 4	5 6 7	8 9 10
Lower back	0 1	2 3 4	5 6 7	8 9 10
Hip(s) L R	0 1	2 3 4	5 6 7	8 9 10
Leg(s) L R	0 1	2 3 4	5 6 7	8 9 10
Knee(s) L R	0 1	2 3 4	5 6 7	8 9 10
Feet L R	0 1	2 3 4	5 6 7	8 9 10
Shoulder(s) L R	0 1	2 3 4	5 6 7	8 9 10
Arm(s) L R	0 1	2 3 4	5 6 7	8 9 10
Wrist/hand L R	0 1	2 3 4	5 6 7	8 9 10
Other:	0 1	2 3 4	5 6 7	8 9 10