MOULDS CHIROPRACTIC

Patient Information

Name:	Male Female
Name I Prefer to be Called:	Marital Status: S M D W
Address:	Date of Birth:
City: State: Zip:	Employer Name:
Home Phone:	Employer Address:
Cell Phone:	City: State: Zip:
Email:	Occupation:
SSN:	Work Phone:

Insurance/Billing Information

Method of Payment: Self Pay or Insurance	
Person Responsible for Balances Due:	
Primary Insurance:	Secondary Insurance:
Name on Policy:	Name on Policy:
Date of Birth:	Date of Birth:
Phone Number:	Phone Number:

Consent to Treat

I authorize Moulds Chiropractic, its physician, Dr. Ryan Moulds, and agents, together with any other company designed by Moulds Chiropractic to perform physical examinations, chiropractic adjustments, and/or other treatment deemed necessary by the treating physician, including but not limited to, any required examinations, x-rays, physical therapy, and other diagnostic/laboratory testing. I understand that as a patient of Moulds Chiropractic, I am authorizing the staff to proceed with medically necessary examinations, diagnostic tests, and treatments. Furthermore, the risks associated with chiropractic care, physical rehabilitation, and/or physical modalities that have been explained to satisfaction. My signature on this document attests to my understanding and that the services for which claims may be submitted have been explained to me. I further authorize Moulds Chiropractic to disclose to the above-named insurer and its designated representatives, test results, and physical findings made during the course of of these examinations and/or treatment, including but not limited to, medical history, treatment, information, laboratory/diagnostic test results, and physical examination findings. I hereby direct the insurer to pay, without equivocation, directly to Dr. Ryan Moulds any and all benefits due as a result of this claim. I am also aware that I am responsible for any charges and/or balances not covered by my insurance. By signing this authorization, I acknowledge that I have read this form, or have had it read to me, that I fully understand its contents, that I have been given ample opportunity to ask questions, and that my question have been answered satisfactorily.

Patient Signature: _____ Date:
Parent or Guardian: _____ Date:

MOULDS CHIROPRACTIC

Assignment of Benefits
Medical Health Insurance Release

Patient Name:
Date of Birth:

I, _____, understand that services rendered to me by Dr. Ryan Moulds are my financial responsibility and that the provider will bill my insurance company, as a courtesy. I authorize my insurance company to pay directly to my provider and I understand that I will be fully responsible for any outstanding balance on my account.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claims by my insurance company.

I authorize the provider to release any information necessary to adjudicate the claims and understand that there may be associated costs for providing information above and beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to my provider within 48 hours. I agree that if I fail to send the payment to the provider and they are forced to proceed to collections process; I will be responsible for any cost incurred by the office to retrieve their monies.

I authorize the provider to initiate a complaint to the insurance commissioner for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Signature of Policy Holder/Guardian: _____

Date:

MOULDS CHIROPRACTIC

Financial Policy

Patient Name:
Date of Birth:

Thank you for choosing Moulds Chiropractic as one of your health care providers. We are committed to the goal of patient satisfaction and the preservation of our health. We will strive to make treatment with us both successful and as pleasant as possible. The following is a statement of our financial policy, which we request that you read thoroughly and sign prior to your treatment. Please speak with our Front Desk Staff should you have any questions.

Payment of your co-pay or time of service fee is due at the time of service. Payment of co-insurance and co-pays are required by most insurance companies, at the time of service. We accept Cash, Personal Check, Visa/MasterCard, Discover and most Debit Cards.

VERIFICATION OF YOUR HEALTH INSURANCE BENEFITS

Moulds Chiropractic staff will ask for your insurance information or a copy of your member identification card. We will make every effort to verify your benefits prior to your treatment in our office. While this verification does not guarantee your coverage, it does provide us with an idea of what to expect from your insurance company. We will review this information with you in detail, should you so request.

THIRD PARTY HEALTH INSURANCE

Moulds Chiropractic does accept third party payer health insurance; however we do require a minimum payment or co-pay at the time of service. That co-pay is usually detailed on the back of your insurance card. Your health insurance contract is between you and your insurer, and while we are not a party to the contract, Moulds Chiropractic can electronically file your claim for you directly to your insurance company. The unpaid account balance is your responsibility should your insurance company refuse to pay their agreed portion. Please be aware that some and perhaps all of the services provided may not be covered by your policy.

INSURANCE – WHEN WE ARE A PARTICIPATING PROVIDER (PPO)

All co-pays and deductibles are due upon treatment. The co-pay is usually detailed on the back of your insurance card. In the event that your insurance coverage changes to a plan where we are not listed as a Preferred Provider, please notify our staff immediately and we will attempt to verify benefits and coverage as an "out-of-network" provider.

USUAL & CUSTOMARY RATES

Moulds Chiropractic is committed to providing the highest quality of care to our patients. Our charges are usual and customary for health care providers of our specialty within our geographical area. Most of our fees are set by the insurance plans that we participate with as a PPO provider, of which, we are contractually obligated to collect co-pays and write-off or write down certain charges.

ADULT PATIENTS AND MINORS & CHILDREN

Adult patients are responsible for payment at the time of service. The adult (parent or guardian) accompanying a minor child is responsible for full payment. For unaccompanied minors, payment is due at the time of service, unless arrangements have been made in advance.

Patient Signature: _____ Date:

MOULDS CHIROPRACTIC

Authorization to Obtain or Release Medical Records from Medical Providers

I hereby authorize Moulds Chiropractic, ("the practice") to obtain any and all medical records concerning my care from any physician, hospital, or other health care professional that has provided medical care to me in the past. I also hereby authorize the practice to release any and all medical records concerning my care to any physician, hospital, or other health care professional providing care to me at any time. Additionally, I authorize the practice to release any and all medical records concerning my care to my insurance company. This authorization expires 5 years from date signed.

Patient Name:
DOB:
Social Security Number:
Patient Signature or Guardian: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with federal government privacy rules implemented through the Healthcare Portability Act (HIPAA), in order for your physician or staff of the Practice to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

____ I hereby give my permission for the practice to leave appointment reminders on my answering machine or text message.

____ I authorize the practice to release any or all information concerning my medical care to individuals listed as set forth below.

____ No one is authorized.

_____ _____
Name Relationship to patient

_____ _____
Name Relationship to patient

_____
Patient/Guardian Signature Date

_____
Witness Date

MOULDS CHIROPRACTIC

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name:
Date of Birth:

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them. I understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient Signature: _____ Date:
Signature of Parent/Guardian: _____ Date:

Printed (Parent/Guardian): _____ Date:

THIS FORM SHALL BE PLACED IN THE PATIENTS CHART AND MANTAINED FOR SIX YEARS

MOULDS CHIROPRACTIC

Your Current Condition

Name: **DOB:** **Date:**

Please indicate, is your current condition:
- □ New injury, illness or problem
- □ Flare-up of a previous condition
- □ Continuation of current problem

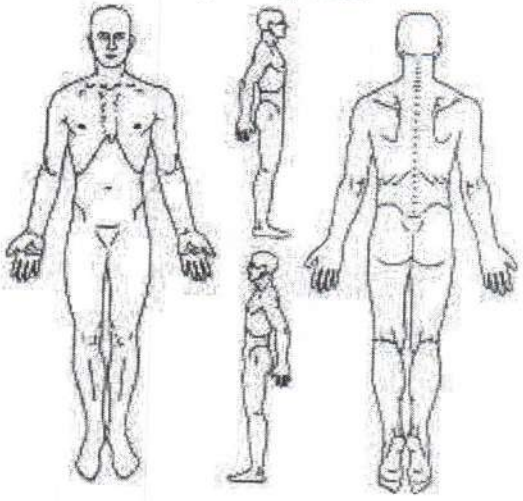
Is your condition the result of:
- □ Work related injury
- □ Automobile accident
- □ Neither

Please explain your condition – when did the problem/pain begin?

_____

_____

Where is your pain?



What type of pain are you experiencing?

Dull	Burning
Aching	Stabbing
Spasm	Numbness
Sharp	Tingling
Shooting	Other: _____

DOES THIS PAIN RADIATE, SHOOT, OR TRAVEL IN YOUR BODY? □ YES □ NO

PAIN RATING: Please rate your pain for each area of the body where you are experiencing symptoms.

1 2 3 4 5 6 7 8 9 10
MINIMAL MILD MODERATE SEVERE VERY SEVERE

Write the number from the scale above next to the area of complaint.

HEAD:_____NECK:_____UPPER BACK:_____MID BACK:_____LOWER BACK: _____

SHOULDER: LEFT____/RIGHT____ **ELBOW/WRIST/HAND**: LEFT____/RIGHT____

KNEE: LEFT____/RIGHT____ **ANKLE/FOOT**: LEFT____/RIGHT____

Please indicate the frequency of your pain:

INTERMITTENT OCCASIONAL FREQUENT CONSTANT

The condition is getting progressively: BETTER STAYING THE SAME WORSE

Is the condition affecting your ability to perform your activities of daily living? If yes, circle below:

bending, lifting, twisting, sitting, standing, driving, sitting at computer, holding objects, performing work duties, home care duties, childcare duties, personal hygiene? □ **No**

Other doctors seen for this condition:

_____

Anything else the doctor should know? □ YES □ NO

If yes, please explain:

_____

_____

Consent to Treat

Please sign below

I authorize Moulds Chiropractic, its physician Dr. Ryan Moulds and agents, together with any other company designated by Moulds Chiropractic to perform a physical examination, chiropractic adjustments and/or other treatment deemed necessary by the treating physician, including but not limited to any required examination, x-rays, physical therapy and other diagnostic/laboratory testing. I understand that as a patient of Moulds Chiropractic, I am authorizing the staff to proceed with medically necessary examinations, diagnostic test, and treatments. Furthermore, the risk associated with chiropractic care and or physical rehabilitation, physical modalities have been explained to my satisfaction. My signature on this document attests to my understanding and that the services for which claims may be submitted have been explained to me. I further authorize Moulds Chiropractic to disclose the above named insurer and its designated representatives, test results and physical findings made during the course of this examination and/ or treatment, including but not limited to, medical history, treatment information, laboratory/ diagnostic tests results and physical examination findings. I hereby direct the insurer to pay, without equivocation, directly to Moulds Chiropractic, Dr. Ryan Moulds, any and all benefits due as a result of this claim. I am also aware that I am responsible for charges and/or balance not covered by my insurance. By signing this authorization, I acknowledge that I have read, or had this form read and explained to me, that I fully understand its contents, and that I have been given ample opportunity to ask questions, and that my questions have been answered satisfactory.

_____ _____

Patient Signature **Date**

MOULDS CHIROPRACTIC

Doctor Reviewed: _____

Report of Medical History

PATIENT NAME: _____ **DOB:** _____ **DATE:** _____

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. If you cannot remember specific details, please provide your best guess.

Review of Systems

Please mark or circle any persistent symptoms you have had in the past few months. Read through every section and check "No problems" if none of the symptoms apply to you.

General

___ Unexplained weight loss/gain
___ Unexplained fatigue/weakness
___ Fall asleep during the day when sitting
___ Fever, chills
___ **No problems**

Skin

___ New or change in mole
___ Rash/Itching
___ **No problems**

Breast

___ Breast lump/pain/nipple discharge
___ **No problems**

Ears/Nose/Throat

___ Nosebleeds, trouble swallowing
___ Frequent sore throat, hoarseness
___ Hearing loss/ringing in ears
___ **No problems**

Eyes

___ Change in vision/eye pain/redness
___ **No problems**

Cardiovascular

___ Chest pain/discomfort
___ Palpitations (Fast or irregular heartbeats)
___ **No problems**

Respiratory

___ Cough/wheeze
___ Snoring/altered breath during sleep
___ Short of breath with exertion
___ **No problems**

Gastrointestinal

___ Heartburn/reflux/indigestion
___ Blood or change in bowel
___ Constipation
___ **No problems**

Genitourinary

___ Leaking urine
___ Blood in urine
___ Nighttime urination or increased frequency
___ Discharge; penis or vagina
___ Concern with sexual function
___ **No problems**

Musculoskeletal

___ Neck pain
___ Back pain
___ Muscle/joint pain
___ **No problems**

Endocrine

___ Heat or cold sensitivity
___ **No problems**

Hematologic/Lymphatic

___ Swollen glands
___ Easy bruising
___ **No problems**

Neurological

___ Headaches
___ Memory loss
___ Fainting
___ Dizziness
___ Numbness/tingling
___ Unsteady gait
___ Frequent falls
___ **No problems**

Psychiatric

___ Anxiety
___ Sleep problems
___ Lack of concentration
___ **No problems**

Allergic/Immune

___ Hay fever/allergies
___ Frequent infections
___ **No problems**

Women Only

___ Pre-menstrual symptoms (bloating, cramps, irritability)
___ Hot flashes/night sweats
___ **PREGNANT ___ MONTHS**
___ **No problems**

If you have any other condition or symptoms not listed above, please list below:

_____

_____

_____

REPORT MEDICAL HISTORY: Do you have now, or have you ever had any of the following? Check or circle below:

___ Diabetes
___ High blood pressure
___ High cholesterol
___ Thyroid disorder_____
___ Cancer (type)_____
___ Lung problem
___ Crohn's disease

___ Colon disorder/colitis
___ Pneumonia
___ Asthma
___ Emphysema
___ Heart problems

___ Heart defibrillator or pacemaker

___Stroke
___Epilepsy (Seizures)
___Liver disease _____
___Kidney disease/stone _____
___Blood disorder
___ Gallbladder disease
___ Hepatis

___Osteoporosis
___ Stomach disorder/ulcer
___ Rheumatologic disorder
___ HIV/AIDS
___ Pancreatic disorder

___Dizziness/vertigo
___ Joint problem _____
____ Spine related disorder

Other Medical Condition (Please List):

_____

_____

FAMILY ILLNESS HISTORY: Has any member of your family had any of the following:

ILLNESS	FAMILY MEMBER	ILLNESS	FAMILY MEMBER
Lung Disease	_____	Heart Disease	_____
Cancer	_____	High Blood Pressure	_____
Kidney Disease	_____	Stroke	_____
Diabetes	_____	Nervous System Disease	_____
Liver Disease	_____	Joint Disorder	_____
Rheumatoid Disease	_____	Other Serious Illness	_____

SURGICAL HISTORY: Please list all surgical procedures and dates. If you cannot remember the exact date, please estimate.

_____

_____

MEDICATIONS: Please list (or show us your own printed records) all prescription and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. Use the back of the page if you need more room. **□ NONE**

_____

_____

ALLERGIES **□ NONE**

_____

SOCIAL HISTORY: Please select use of the following:

Tobacco Use:
Do you smoke? Yes or No

Caffeine Use:
Do you drink caffeine? Yes or No

Alcohol Use:
Do you drink alcohol? Yes or No **Patient Name:**