Consultation History

Patient's Name: _____ Date:_____

Major Complaint: _____

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

Is the pain: Dull Achy Sharp Burning Sore Stiff Throbbing Excruciating

How Long: _____

How Often: Occasional_____ Intermittent ____

Frequent _____ Constant _____

Severity: Mild ____ Mild-Moderate____ Moderate ____

Moderately-Severe _____

Severe _____

Before you noticed these symptoms, were there any accidents, injuries, or physical stress which may have injured your spine and nervous system? Repetitive? _____

_____

What have you tried to do to get rid of the problem:

_____

_____

Now, is there anyone else in your family who has health problems, even if they are not the same as yours? _____

_____

GREAT LAKES FAMILY CHIROPRACTIC

CASE HISTORY

Name _____ Date _____

Address _____ City _____

State _____ Zip _____ Home Phone _____

Cell Phone _____ Work Phone _____

Birth Date _____ Age _____ E-mail _____

Referred By _____ Soc. Security # _____

Occupation _____ Employer _____

Marital Status: S M D W Race/Ethnicity _____

Spouses Name _____

Spouses Occupation _____ Number of Children _____

Female Only: Are you pregnant? Yes _____ No _____

Have you ever received chiropractic care? Yes _____ No _____

Preferred Language _____ Do you smoke? _____

Signature of Patient _____ Date _____

About Your Health

The human body is designed to be healthy. Throughout life, events occur which can damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that resulted in poor health. Following your exam, Dr. McKenzie will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

GREAT LAKES

FAMILY CHIROPRACTIC

MEDICATION INFORMATION

Please take a moment to list any medications that you are currently taking, including the daily dosage. This information is helpful to us before you begin treatment in our office.

Medication	**Daily Dosage**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any allergies to medications? If so please list them

_____

_____

_____

_____

Do You Smoke: Yes/No

Print Name: _____

Signature: _____ **Date:** _____

Dr. Douglas McKenzie, D.C.
3138 Broadmoor Ave. SE Kentwood, MI 49512

Authorization, Assignment, Acknowledgment and Understanding

AUTHORIZATION TO RELEASE INFORMATION: Great Lakes Family Chiropractic is authorized to release any information that it deems appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by Great Lakes Family Chiropractic, including its designated associates and assistants and hereby release Great Lakes Family Chiropractic from any consequence and/or liability concerning the same.

ASSIGNMENT OF PAYMENT: My attorney and/or insurance company are hereby requested to pay directly to Great Lakes Family Chiropractic any monies due it on account, the same to be deducted from any settlement made of my behalf. Further, it is understood and agreed that I shall pay the full amount of the charges, should my condition be such that it is not covered by my insurance policy or if for any reason the insurance company and/or attorney refuses and/or fails to pay my claim.

UNPAID INSURANCE BALANCE: I understand and agree that should there be any unpaid insurance balance for sixty (60) days, such balance shall automatically become my responsibility.

MEDICARE ASSIGNMENT: 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 carriers any information needed for this or a related Medicare claim. I authorize 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 below.

CONSENT TO CARE FOR A MINOR: I hereby authorize Great Lakes Family Chiropractic to administer care as deemed necessary to: _____.

OBLIGATIONS AS TO SERVICES: I hereby acknowledge that I am receiving (or about to receive) health care services at Great Lakes Family Chiropractic and that I have been advised that Great Lakes Family Chiropractic is willing to wait for payment for these services so long as there continues to be a likelihood that payment will be made either by my insurance company and/or out of the settlement of my liability case.

I understand and agree that, in the event that:

A. It is determined that there is no insurance company obligation to pay for Great Lakes Family Chiropractic's services;
B. The insurance company for the undersigned refuses to acknowledge an assignment to Great Lakes Family Chiropractic or to take other actions for the protection of the interest of Great Lakes Family Chiropractic;
C. My attorney fails and/or refuses to agree to protect the interest of Great Lakes Family Chiropractic as determined in its sole discretion; or
D. I fail to retain an attorney

then payment of services at Great Lakes Family Chiropractic will be made on a current basis and my bill paid in full within sixty (60) days from my last treatment. Two months of non payment will result in a late fee of $20 per month. After 6 months a collection fee will be added and it will be sent to collections.

INTEREST AND COLLECTION: I acknowledge and agree that, should my account become more than one hundred and eighty (180) days overdue, I will incur interest on my past due balance of forty five percent (45%). I further acknowledge and agree that Great Lakes Family Chiropractic shall be entitled to reimbursement from me for any legal costs, including attorney fees, for all efforts to collect on any past due account with Great Lakes Family Chiropractic.

By my signature below, I make the foregoing authorizations, assignments and agreements.

_____ _____

Patient Name (Please Print) Patient Signature

Professional Courtesy

By my signature below, I request and authorize Great Lakes Family Chiropractic to provide my medical doctor with a report for my medical record. Please send to:

_____ _____

Name of Medical Doctor Office Name

_____ (_____) - _____

Office Address Telephone

_____ _____

Patient Name (Please Print) Patient Signature

ASSIGNMENT OF BENEFITS

As a courtesy to me, **Great Lakes Family Chiropractic** will call and verify my insurance coverage. Whenever a call is made to an insurance company regarding benefits, the following statement is given by the representative: **"Please note that benefits stated by a representative are not a guarantee of payment. A determination as to the eligibility of an individual, and the amount of benefits, if any, can only be made after a claim is submitted and fully investigated. Each claim is subject to all group plan provisions."** My insurance company is not promising to pay for care. However, in the majority of cases, insurance companies pay what they state on the phone. It is my responsibility to see that my account is paid, regardless of insurance coverage. An insurance contract is between me and my insurance company. **Great Lakes Family Chiropractic** will bill my insurance as a courtesy, and any information given to me by the doctor or staff carries the same stipulation as noted above.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in my case.

A photocopy of my Insurance card shall be considered as effective and valid as the original.

If necessary, I authorize the doctor or staff to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

WE WILL NEED A COPY OF YOUR CARD

Cardholder Name (if different than Patient)_____

Cardholder's Date of Birth (if different than patrient)_____

Will you be using a Health Savings Account to pay for care? Yes _____ No _____

I have read and I understand the above policies. I agree to pay any balance due by me, over and above my insurance payments, according to the financial plan set up by Great Lakes Family Chiropractic and agreed to by both parties.

Signature of Patient _____ Date _____

Great Lakes Family Chiropractic
3138 Broadmoor Ave. SE. Kentwood, MI 49512 616-575-9105

PATIENT CONSENT

Notice of Privacy Practices

I acknowledge that Great Lakes Family Chiropractic's "Notice of Privacy Practices" has been made available for me to read.

I understand that I have the right to review Great Lakes Family Chiropractic's "Notice of Privacy Practices" prior to signing this document. The "Notice of Privacy Practices" describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of charges, or in the performance of health care operations at Great Lakes Family Chiropractic. This "Notice of Privacy Practices" also describes my rights and Great Lakes Family Chiropractic's duties with respect to my protected health information.

Great Lakes Family Chiropractic reserves the right to change the privacy practices that are described in the "Notice of Privacy Practices" as required by law. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

I have read and I understand the above policies.

Signature of Patient _____

Date _____ Witness _____

GREAT LAKES

FAMILY CHIROPRACTIC

3138 BROADMOOR AVE. SE

KENTWOOD, MI 49512

(616) 575-9105

Emergency Contact Sheet

Name: _____

1st Contact: _____

Address: _____

_____

Phone: _____

Relationship: _____

2nd Contact: _____

Address: _____

_____

Phone: _____

Relationship: _____