LYKENS CHIROPRACTIC, INC.

Optimum Health For Your Entire Family

Appt: Patient #

PATIENT INFORMATION

Name_____ Date _____ Referred by_____
First MI Last

Address_____ City/State/Zip_____

Phone # _____ Cell # _____ Email Address _____

Social Security #_____ Birth Date _____ Gender: Male___ Female___

Weight _____ Height ____' ____" Preferred Language _____

CMS requires providers to report both race and ethnicity:

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Marital Status: married___ divorced___ single___ separated___ widowed___ Number of children_____

Current Employer_____ Occupation_____

Employer Address (if known) _____ Work Phone # _____

EMERGENCY CONTACT/PARENT INFORMATION

Name _____ Relationship _____ Phone # _____

FEMALE PATIENTS RECEIVING X-RAYS

Here at LYKENS CHIROPRACTIC, Inc., we want to ensure that each and every patient receives the safest care possible. If by chance you are pregnant, it is important that we protect you from any unnecessary radiation that could affect the development of an unborn child in uterus.

Is there a chance that you may be pregnant at this time? ___YES ___NO Date of last menses_____

By signing your name below, you deny pregnancy at this time and give permission to proceed with your X-ray if needed.

*Signature*_____ *Date*_____

PURPOSE FOR TODAY'S APPOINTMENT

*(Please **X** all that apply)*

Maintaining a healthy lifestyle_____ Enhancing athletic performance_____ Prevention of illnesses_____
Relief for a specific injury or condition_____ Improving your overall health without drugs or surgery_____

Please list below the main complaints you have in order of their importance.

1._____ How long? _____
2._____ How long? _____
3._____ How long? _____
4._____ How long? _____

What caused today's problem? *(give date if known)* _____
Have you experienced this problem in the past? ___Yes ___No If so, when? _____
Describe your pain or discomfort *(dull, sharp, burning, tingling, pins & needles, stabbing, numb, etc)* _____
_____
Does this problem stay in one area or travel somewhere else? _____
Are you experiencing any restrictions in your range of motion? If yes, which joints? _____
What makes it better? *(sitting, standing, walking, lying down, etc)*_____
What makes it worse? _____
Have you seen anyone else for this condition and when? _____
Have you taken anything for this condition since it began or tried something to help your problem? (i*f yes, explain)*
_____
Have you had an MRI or any other imaging of the spine done? YES/NO If yes, when and where _____
_____
How has this affected your daily activities? _____

HEALTH CARE HISTORY

Do you regularly consult any of the following care providers? (check all that apply)
___Medical Physician ___Naturopath ___Acupuncturist ___Homeopath ___Psychotherapist ___Dentist
Name and reason why: _____
_____
Date of last medical examination_____ Were there any complications? _____
Have you been to a Chiropractor before? YES / NO Date of last adjustment_____ Chiropractor_____
Reason for previous chiropractic care_____
How often did you go? ___Regular monthly check-ups ___Bi-weekly ___Weekly ___Only when needed
Why did you discontinue care?_____
Are you or have been treated by a Physical Therapist? YES/NO How often are you being seen? _____
Have you ever had a professional massage before? YES/NO If yes, when was your last visit: _____
Do you have a pressure preference with massage? ___ Light Pressure ___ Medium Pressure ___ Deep Pressure
Are you sensitive to fragrances, perfumes, or nut oils? YES/NO If yes, please explain _____

PAST HISTORY

Have you had any accidents related to any of the following? (check all that apply)
___Automobile ___Motorcycle ___Bicycle ___Sports ___Playground ___Abuse
If yes, please explain how and dates: _____
_____
Have you ever injured your spine (head, neck, rib/chest area, back, pelvis, or hips)? ___Yes ___No
If yes, please explain how and dates: _____
Have you ever been hospitalized? ___Yes ___No If yes, please explain why and for how long: _____
_____
List any other injuries or accidents & dates_____
List any surgeries & dates_____
List anything that you have been diagnosed with *(past or current)* _____

(PLEASE FILL OUT BACK OF FORM)

PAST HISTORY CONTINUED

Do you have a family history of ___arthritis ___cancer ___diabetes ___heart disease ___scoliosis?
Do you or have you ever used tobacco products? YES / NO If yes, former smoker___ current smoker___ #___per day
If yes, what year started _____ and/or what year stopped _____
Have you been exposed to any of the following on a regular basis, (past or present)?
___Toxic chemicals ___Drugs (prescribed or not) ___Second hand smoke ___Other
If yes, please explain: _____
Prescription and non-prescription medication may cause various side effects, hide the severity of health problems, and hinder the body's ability to heal. Are you currently taking any medications? (Include regularly used over the counter medications)

Medication Name	Treating	Dosage and Frequency

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

What vitamins or other nutritional supplements do you take? _____
How often do you consume the following? Coffee/caffeine #___ per week Alcohol #___ per week Diet soda #___per week
Do you exercise? YES / NO How often and what activities? _____
How many servings of **RAW** fruits and vegetables do you consume per day? _____
Do you get sufficient sleep at night? YES/NO _____
How much water do you drink throughout the day? _____

PAST & PRESENT CONDITIONS

(Please X all that apply)

___Neck pain (right/left)
___Headaches
___Numbness in arms, hands, fingers
___Ear Infections
___Frequent Colds or Flu
___Allergies/Sinus Problems
___Loss of Taste or Smell
___Dizziness
___Blurred or Doubled Vision
___Convulsion/Epilepsy
___Stroke, Date _____
___Pass Out
___Trouble Concentrating
___Trouble Sleeping
___Nervousness/Anxiety
___Mental/Emotional Disorders:_____
___ Jaw Pain/Clenching

___Asthma/Difficulty Breathing
___Shoulder Pain (right/left)
___Chest Pain
___Heart Problems
___High/Low Blood Pressure
___Digestive Problems/Heartburn
___Ulcers
___Gall Bladder Problems
___Mid-Back Pain/Stiffness
___Hip Pain (right/left)
___Numbness in legs, feet, toes
___Knee Pain (right/left)
___Kidney Troubles
___Frequent/Difficulty Urination
___Diarrhea/Constipation
___Colon Trouble
___Hemorrhoids

___Excessive Gas
___Liver Problems
___PMS/Menstrual Problems
___Impotence
___Prostate Problems
___Hernias
___Blood Clots
___Varicose Veins
___Arthritis/Tendonitis
___Swollen/Painful Joints
___Joint Replacements: _____
___Fractured Bones: _____
___Muscle Spasms
___Fibromyalgia
___Cancer/Tumors
___Abnormal skin condition
___Contagious or Infectious Diseases

QUALITY OF LIFE

How do you grade your physical health? ___Good ___Fair ___Poor
How do you grade your emotional/mental health? ___Good ___Fair ___Poor
How do you rate your overall "quality of life"? ___Good ___Fair ___Poor
How do you rate your current diet/nutritional state? ___Good ___Fair ___Poor
How do you rate your level of negative stress? ___High ___Moderate ___Low

Patient Signature_____ **Date**_____

LYKENS CHIROPRACTIC, INC. FINANCIAL POLICIES

Thank you for choosing Lykens Chiropractic as your health care provider. We are committed to the success of your treatment. The following are statements of our Policies, which we require you read and sign prior to any treatment. All patients must complete our Patient Information, Health Information, Policy and Coverage forms before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. WE ACCEPT CASH, CHECKS, CREDIT AND DEBIT CARDS. RETURNED CHECK FEE: THERE WILL BE A $20 FEE PER RETURNED CHECK IF YOUR CHECK IS NOT HONORED BY THE BANK UPON FIRST DEPOSIT. WE OFFER AN EXTENDED PAYMENT PLAN WHERE NECESSARY AND WHERE THIS FINANCIAL AGREEMENT IS SIGNED.

REGARDING INSURANCE

We currently participate with Anthem Blue Cross Blue Shield and therefore may accept assignment of insurance benefit provided that your condition requires medically necessary care as this term is *defined by your insurance company*. By signing this agreement, you agree to assign your insurance benefits and all appeal rights under ERISA or any other right of appeal of an adverse benefit determination to this clinic. Where your insurance plan does not permit such an assignment of ERISA appeal rights, you agree to appoint this clinic as your authorized representative in such an appeal. In cases where benefit payments are not assignable, you agree to submit payments during the time of service to Lykens Chiropractic. _____ (Initials).

Your commercial insurance plan is a contract between you and your insurance company. Lykens Chiropractic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from Lykens Chiropractic is your responsibility whether your insurance company pays or not. While we will use reasonable efforts to ensure that your insurance carrier properly processes your services for payment, the obligation to enforce the terms of your benefit contract is your responsibility. _If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, any balance remaining will be due and payable immediately. _____ (Initials).

Out of Network Benefits Submission - If your case presents as eligible for compensation by your insurance company for out of network benefits you will be required to pay for your treatment based upon our usual and customary fees. Your insurance company may reimburse all, none or part of these fees. We will, as a courtesy to you, provide you a superbill for you to submit to your insurance plan but cannot guarantee reimbursement for services performed.

NOTE: Please be aware that some, and perhaps all, of the services provided may be non-covered services and/or not considered reasonable and necessary under your insurance program. If you are unsure as to the nature of the service you are receiving, please ask your doctor. For coverage information, it is your responsibility to review your benefit contract. _____ (Initials).

REGARDING DEDUCTIBLE AND CO-INSURANCE/CO-PAYMENT OBLIGATIONS.

By law we are required to make reasonable efforts to collect deductibles and co-insurance and/or co-payment obligations for covered services as assigned by your insurance carrier. All co-insurance and/or co-payments and deductibles are required to be paid under the terms of your contract with your insurance carrier. By law we are responsible to attempt collections of these amounts once they are identified to us on your explanation of benefits. It is the policy of this clinic to collect all co-insurance, co-payment and deductible amounts. _____ (Initials). If you have difficulty meeting your full responsibility

under the terms of your insurance contract, please contact a member of our billing staff so that financial arrangements for payment can be made.

USUAL AND CUSTOMARY FEES

Our practice is committed to providing the best treatment for our patients and we charge what we reasonably believe to be usual and customary based on a number of factors. Our fees are generally considered to fall within the acceptable range by most companies and the charge for each service is determined based on the relative value (RVU) of the service as published by the Center for Medicare/Medicaid Services (CMS). Not all carriers utilize CMS RVU's when determining their allowances for a service. Many carriers implement an arbitrary schedule of allowances. Notwithstanding any contractual provision to the contrary between Lykens Chiropractic and your health insurance carrier, Lykens Chiropractic will accept your carrier's fee schedule allowance as full payment for any service rendered provided that you meet any co-insurance, co-payment and/or deductible obligation assigned by your carrier within 60 days of the date of the carrier's determination as expressed on your explanation of benefits. This statement does NOT mean that we accept the insurance company's payment as payment in full. Your carrier generally only pays a portion or percentage of the allowed fee for a particular service in accordance with the terms of your benefit plan. Deductible, co-insurance and/or co-payment amounts are your responsibility. _____ (Initials). Where you fail to provide payment of the amounts assigned to you by your insurance carrier within 60 days of your carrier's determination, the amounts in excess of your insurance carrier's fee schedule allowance will be due and payable. Where a service is not covered under your benefit plan, you will be responsible for the fee charged for such services. **Non-covered services, including maintenance, palliative and preventive physical medicine and/or chiropractic services will not be billed to your insurance company as these services are never covered.** By executing this Agreement, you indicate your understanding and Agreement with this policy. _____ (Initials). Finally, we reserve the right to appeal your carrier's determination regarding the amount allowed for any service we provide where the amount allowed is less than the amount charged. The amount you may be responsible for could therefore change depending on the outcome of such an appeal.

NON-COVERED SERVICES

Your care may involve services that are not covered under your health benefit plan and include services that may be considered injury prevention, palliative care, wellness care, maintenance care and/or general exercise. You have the right to deny receipt of these services. If you elect to receive a non-covered service that is recommended or necessary to your care, you will be fully responsible for payment of these services and consistent with the provision above, you agree that these services will not be reported to your insurance carrier. Even where the Lykens Chiropractic is a participating provider with your insurance plan, it is not obligated to report non-covered services on your behalf. _____ (Initials).

Where circumstances permit, we will attempt to verify the limitations of your health insurance benefit plan recognizing that you have the ultimate responsibility for knowing and understanding the coverage limitations of your insurance benefit contract. As the information we receive is not a guarantee of coverage or benefits, we cannot be responsible for the validity of the information supplied to us by your carrier. You are responsible to verify your coverage limitations based on your benefit contract. _____ (Initials). Fees charged for non-covered services will be determined by the clinical presentation and agreement between Lykens Chiropractic and the patient. Non-covered services may qualify for HSA and as a medical expense; a receipt can be supplied for documentation of these services if needed.

MISSED APPOINTMENTS

Please help us serve you better by keeping scheduled appointments. Further, understand that non-compliance with your ordered treatment plan may negate our ability to represent your services as medically necessary to your insurance carrier. This is to remind you that in order for the services performed in this clinic to be billed to your insurance carrier, those services must be considered to be medically necessary. Part of satisfying the medical necessity requirement is for this clinic to develop a treatment program that is oriented toward improving your level of function as a means of meeting your activity demands. Our ability to assist you with meeting these goals is in significant part based on your commitment to your ordered treatment program. Non-compliance with your treatment plan will interfere with our ability to make the progress that is required by your carrier to establish the medical necessity of the services such that they become covered by your insurance plan. If you are non-compliant with your ordered treatment plan you will be discharged from that plan. If this is the case, you will be offered non-covered maintenance treatment on a schedule that you can determine. This type of treatment; however, is not a covered benefit under insurance plans and this clinic will not bill these services to your carrier. The burden of payment for this type of treatment will be your responsibility. For a missed chiropractic appointment, the fee will be $20. For a massage therapy appointment, you will be charged a pro-rated fee of $10 for each 15 minute interval missed including late arrivals. _____ (Initials).

PERSONAL INJURY/WORKERS' COMPENSATION

Lykens Chiropractic, Inc. does not accept New Patients as personal injury/ motor vehicle accident or workers' compensation cases. In the event that you need to file a personal injury/ MVA or W.C. case as an established patient, you will be responsible for payment at the time of service. As a courtesy we will provide copies of records upon request _____ (Initials).

FINANCIAL ARRANGEMENTS

Where necessary based on your financial circumstances, we will permit you to make payment arrangements that will permit you to meet the obligations detailed in your insurance benefit contract and this policy. Strict adherence to the financial arrangements you make is required. You must relay any changes you may require to your previously agreed financial arrangements to our financial department immediately. Past due balances that cannot be handled in house will be referred to outside collection agencies or to litigation for collection. Where this is necessary, you agree to be additionally responsible for any costs and attorneys' fees related to the collection of unpaid amounts. Additionally, any reduction in our usual and customary fees for the services you receive based on the allowed amount by your insurance carrier (as explained above) will be reversed and you will be responsible for these amounts as well.

By providing the information below, I, the undersigned (see Credit Card Holder's Signature), have read, understand and agree to the above policies and further agree to be responsible for any deductible, co-insurance, co-payment amount assigned to me by my insurance carrier as well as any amount due for non-covered services I receive. In the event that other payment arrangements are not made and agreed to by Lykens Chiropractic, they are authorized to charge any amount due to the credit card on file. The undersigned further represents possession of the authority to grant such an authorization related to the billing of amounts due to Lykens Chiropractic to the credit card on file. The undersigned understands that the authorization to bill the credit card on file for incurred charges may be terminated, but in such event the undersigned agrees to provide Lykens Chiropractic with reasonable notice of termination. "Reasonable notice" is defined as written notice at least 30 days in advance of termination of the authorization. Should there be any change relating to the credit card information on file, the undersigned

agrees to provide updated information to Lykens Chiropractic prior to the end of the month in which such changes occur or upon demand. The undersigned further understands that termination of the authorization to bill unpaid fees for services received to the credit card on file does not alleviate the undersigned patient from the responsibility to pay any amount that became due prior to or after notice of termination is provided.

I have read and agree to these clinic policies and authorize payment of any insurance benefits to Lykens Chiropractic and further authorize Lykens Chiropractic to bill my credit card as detailed above or where no credit card information is provided, agree to complete a financial agreement related to payment for services received but not paid for in full by my insurance benefit plan. In the event of non-payment of insurance benefits, I authorize Lykens Chiropractic to pursue any appeal of such a denial of payment by my insurance company and further grant to Lykens Chiropractic any appeal rights that I may have under the terms of my insurance benefit contract or any state or federal statute including the federal E.R.I.S.A. statute.

_____ _____

Signature of Patient or Responsible Party/Guardian Date

_____ _____

Signature of Staff Witness Date

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES – RELEASE OF INFORMATION

Lykens Chiropractic is concerned about the privacy of your individually identifiable health information and has enacted policies and procedures to protect your privacy as required by the Health Insurance Portability and Accountability Act of 1996. A notice of this clinic's privacy practices is posted in the clinic or can be obtained from a staff member. Your acknowledgement of "receipt" of the Lykens Chiropractic Notice of Privacy Practices or our good faith effort to obtain your acknowledgement permits Lykens Chiropractic to release your protected health information for purposes of treatment, payment, or healthcare operations only.

I acknowledge that I have received the Notice of Privacy Practices for protected health information.

_____ _____

Signature of Patient or Responsible Party/Guardian Date