DALLAS CHIROPRACTIC RELIEF, PLC

John Lafayette Dallas, B.Sc., D.C., C.C.S.P
Certified Chiropractic Sports Physician
1505 WEST HOLMES ROAD, LANSING, MICHIGAN 48910
Phone (517) 882-0251 Fax (517) 882-2724
www.drjohndallas.com

Patient Information

* * * * * * * * * * * * *

Name:_____

Address:_____

City:_____

State:_____ **Zip Code**:_____

SS#:_____

Gender: M F **Date of birth:**_____

Marital Status: Single Married Divorced

Occupation:_____

Employer/School:_____

Spouse's Name:_____

Spouse's Date of birth:_____

Children? Y N **Ages:**_____

Insurance Information

* * * * * * * * * * * * *

Insurance:_____

Policy Number:_____

Group Number:_____

Subscriber's DOB (if different form patient)**:**_____

Secondary Insurance:_____

Contact Information

* * * * * * * * * * * * *

Home:_____ **Cell:**_____

Work:_____ **Other:**_____

May we leave a message? Y N

E-mail:_____

Emergency Contact:_____

Relationship:_____

Phone Number:_____

Primary Dr:_____ **Phone #:**_____

Accident Information

* * * * * * * * * * * * *

Condition related to an accident? Y N

Date of accident:_____

Type of accident: Auto Work Home Other

Who have you made a report of your accident to?

Auto Insurance Attorney Employer

Insurance Authorization

* * * * * * * * * * * * *

I authorize the release of any medical information necessary to process my insurance claim and payment of medical benefits to Dallas Chiropractic Relief, PLC for the services described on the insurance claim. This authorization is to apply to all occasions of service until it is revoked in writing.

Consent for Treatment

* * * * * * * * * * * * *

I acknowledge that Dallas Chiropractic Relief, PLC's "Notice of Privacy Practices" is available for my review upon my request. I understand I have a right to review this information prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected heath information that will occur in my treatment, payment of my bills, or in the performance of health care operations of the Dallas Chiropractic Relief, PLC. This Notice of Privacy Practices also describes my rights and the Dallas Chiropractic Relief, PLC's duties with respect to my protected health information. Dallas Chiropractic Relief, PLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a copy of the 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.

Date:_____ **Signature:**_____

Patient Condition

* * * * * * * * * * * * *

Reason for visit:_____

How and when did your symptoms first occur?_____

Have you seen any other doctors for this condition? If so, who?_____

Present Weight:_____ **Height:**_____

Are you currently pregnant? Y N **Due Date**:_____ **Number of previous pregnancies**:_____

Tobacco:_____ packs per day **Alcohol:**_____ drinks per day/week

Exercise: None Moderate Daily Heavy **Work Activity:** Sitting Standing Light Labor Heavy Labor

Please circle any of the following conditions that you have had:

Abdominal pain	Chest pains	Heart attack	Low back pain	Prosthesis
AIDS/HIV	Chronic sinusitis	Heart disease	Lupus	Scoliosis
Allergy shots	Diabetes	Hepatitis	Mid-back pain	Shoulder pain
Anemia	Depression	Hernia	Migraines	Stroke
Anorexia	Dizziness	Herniated disc	Multiple sclerosis	Thyroid issues
Appendicitis	Emphysema	High blood-pressure	Neck pain	Tuberculosis
Arthritis	Endometriosis	Hip pain	Pacemaker	Tumors
Asthma	Epilepsy	Jaw pain	Parkinson's Disease	Ulcers
Blood disorders	Gallbladder issues	Kidney stones	Polio	Vision problems
Breast lumps	Goiter	Liver disease	Prostate issues	
Cancer	Gout			

Injuries/Surgeries You Have Had:

_____

_____

_____

List ALL Current Medications:

_____

_____

_____

How did you hear about us? Please check ALL that apply:

☐ Word of Mouth (Name of person who told you about our office): _____

☐ Our website ☐ Google ☐ AT&T Yellow Pages Phone Book ☐ Insurance Company Website

☐ M.D. Referral (Name):_____ ☐ Other (please explain):_____

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify Dallas Chiropractic Relief, PLC immediately whenever I have changes in my health condition or health plan coverage in the future.

Date:_____ **Signature:**_____

DALLAS CHIROPRACTIC RELIEF, PLC

John Lafayette Dallas, B.Sc., D.C., C.C.S.P
Certified Chiropractic Sports Physician
1505 WEST HOLMES ROAD, LANSING, MICHIGAN 48910
Phone (517) 882-0251 Fax (517) 882-2724
www.drjohndallas.com

The objective and philosophy of Dallas Chiropractic Relief, PLC is to ensure our patients receive the best possible care and service. Therefore, your complete understanding of our procedural and financial policies is essential. Please read this document thoroughly, then sign and date it below indicating you understand and agree to comply with this policy.

PROCEDURAL POLICY

- Dallas Chiropractic Relief, PLC is authorized to release any information, pertinent to your case, to other insurance companies, adjusters, doctors, transcriptionists, collection services (bills only), or attorneys involved in this case, and you hereby release this clinic of any consequence thereof.

- The information you have given this clinic relative to your condition and history is correct to the best of your knowledge and you do not hold the doctor or his staff members responsible for any errors or omissions that you may have made in the completion of this form.

- It is understood that chiropractic treatment is not an exact science and that Dr. Dallas cannot guarantee the results. You acknowledge that no guarantee or assurance is provided in the chiropractic treatment that you have requested and authorized. You will not be treated until you have had all your questions on risks of procedure answered to your satisfaction. Risks of chiropractic are extremely rare and have never occurred in Dr. Dallas' 22 years of practice. These risks include fracture, stroke and disc problems or slipped disc.

- If x-rays are taken, you will be responsible to make sure you review your x-ray report with Dr. Dallas. If he so instructs, you will receive a copy of your x-ray report and you will take it to your medical doctor. **If you are pregnant, or not sure if you are pregnant, you will not allow x-rays to be taken**.

- Dr. Dallas and his staff are authorized to treat your minor child with chiropractic, x-rays, hot packs, cold packs, massage, or any other treatment deemed appropriate by the doctor.

FINANCIAL POLICY

- You understand that if you are claiming a work-related injury, you are considered a cash paying patient at Dallas Chiropractic Relief, PLC until you bring the clinic written, signed, and dated authorization for treatment from your employer.

- You agree to be financially responsible for all charges incurred at Dallas Chiropractic Relief, PLC, including your insurance deductible, co-payment, and any service rejected by your insurance company. You understand that if the bill is not paid in 30 days, a finance charge and interest may be added.

- You hereby instruct your insurance company to pay, by check mailed directly to Dallas Chiropractic Relief, PLC, the medical expense benefits allowable to you as payment toward total charges for professional services rendered by this clinic.

- If you are a member of a health plan that Dallas Chiropractic Relief, PLC participates with, we will submit your claim to this organization. Your co-payment is expected at the time services are rendered.

- If Dallas Chiropractic Relief, PLC does not have an agreement with your insurance carrier, our insurance department will bill the insurance company as a courtesy to you; however, you are still responsible for the full payment at the time services are rendered.

- It is your responsibility to call your insurance company to inquire about all charges that may be rejected by your health plan and bring this information back to our insurance department so we can decide if rebilling will yield payment.

- Medicare patients are responsible for their deductible, co-payment, and any services Medicare might deem as "medically unnecessary" on the day of service.

- Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. For minors, the parent who accompanies the minor for their first visit will be financially responsible for all charges incurred.

- Patients will be billed in full for any services that the health plan deems as "not a benefit" or a "non-covered service."

- There may be additional charges applied to your account if Dallas Chiropractic Relief, PLC is asked to participate in a deposition, phone consultation, copying of medical records, or completion of forms pertaining to your medical history.

- Dallas Chiropractic Relief, PLC accepts cash, personal checks, money orders, MasterCard, and Visa credit card as payment for services rendered.

- A $25 fee will be assessed for any check returned not cashed. At that time, cash, charge, or money order will be accepted for payment.

- Dallas Chiropractic Relief, PLC reserves the right to turn any account over to collections if it is deemed that the account has been in default of payment.

- In the event you are unable to make your scheduled appointment, please provide notice at least 24-hours prior to the appointment. Dallas Chiropractic Relief, PLC reserves the right to bill our standard office visit fee for non-compliance.

I have read and understand the above policies and I agree with the terms outlined.

Signature:_____ **Date:**_____

Signature of Responsible Party