SPINE & SPORTS
CHIROPRACTIC

Electronic Health Record:

Patient Name: _____

Indicate if an immediate family member has had any of the following:

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Auto Immune ☐ ____ ____

Are you currently taking any prescribed or over the counter medications (vitamins excluded)?	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Family Medical History *(Record one diagnosis in your family history and the affected)*

Diagnosis	Father	Mother	Sibling:	Offspring:
Example: Heart Disease				

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

List all surgical procedures you have had and times you have been hospitalized:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Patient Signature: _____ Date: _____

In compliance with Medicare requirements for the govemment EHR incentive program

For Office Use Only:

Height: _____ Weight: _____ Blood Pressure: ____/____

Patient Financial Responsibility Agreement

By signing below, the patient acknowledges and agrees to the following terms regarding their treatment and insurance coverage:

1. Insurance Billing and Patients Responsibility:

   The healthcare provider will submit claims to the patient's insurance company for therapy, lumbar braces, wrist braces, kinesiology tape, and any other medically necessary services or items provided. However, if the insurance company denies coverage or fails to pay in full to any billed services or items, the patient agrees to remain fully responsible for any outstanding balances, including but not limited to copayments, coinsurance, deductibles, and charges for non-covered services or items.

2. Denial of Coverage:

   If the insurance company denies coverage for any service, item, or therapy (including lumbar braces, wrist braces, kinesiology tape, etc.), the patient acknowledges and agrees that they will be held financially responsible for the full amount due, regardless of the reason for denial. The patient understands that it is their responsibility to verify and understand the terms of their insurance coverage, including what services or items are covered and at what rates.

3. No Guarantee of Coverage

   The healthcare provider does not guarantee their any services, treatments, or items will be covered by the patient's insurance provider. It is the patient's responsibility to ensure that the services being rendered are covered under their insurance plan.

4. Outstanding Balances:

   ff the patient is unable to pay the balance in full at the time of the bill, they are encouraged to discuss payment arrangements with the healthcare provider. However, any unpaid balance remains the responsibility of the patient, and nonpayment may result in collection actions, including but not limited to referral to a collection agency.

5. Understanding and Agreement:

   The patient affirms that they have read, understand, and agree to the terms set forth in this Financial Responsibility! Agreement. The patient acknowledges that they are financially responsible for any charges not covered by insurance, as outlined above.

Signature of Patient/Guardian: _____

Date: _____