Phone Number:

Patient Information

Date: _____ SSN: _____ Birthday: _____

First Name: _____ Middle Name: _____ Last Name: _____

Sex: ◯M ◯F Height: _____ Weight: _____

Marital Status: ◯Yes ◯No Spouse Name: _____ # of Children: _____

Home #: _____ Cell #: _____ Work #: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Emergency Relation: _____ Emergency Phone: _____

Email: _____

Referral Information

Referring Physician: _____ Referred Patient: _____ Referred by: _____

Advertisement: ◯Yes ◯No Advertisement: _____

Referred Directory: ◯Yes ◯No Referred Directory: _____

Employer Information

Employed: ◯Full Time ◯Part Time ◯Homemaker ◯Unemployed Employer Name: _____

Employer Address: _____

Employer City: _____ Employer State: _____ Employer Zip: _____

Occupation: _____ Work Supervisor: _____ Supervisor #: _____

Work Duties: _____

Insurance Information

Payment: ◯Personal ◯3rd Party ◯Self Resp. for Payment: _____ Responsible Phone : _____

Payment Name: _____ Primary Phone #: _____ Primary ID/Policy: _____

Payment Address: _____

Payment City: _____ Payment State: _____ Payment Zip: _____

Primary Group #: _____ Primary Name: _____ Primary DOB: _____

Secondary Name: _____ Secondary Phone #: _____ Secondary ID/Policy: _____

Secondary Address: _____

Secondary City: _____ Secondary State: _____ Secondary Zip: _____

Secondary Group #: _____ Secondary Name: _____ Secondary DOB: _____

Claim #: _____ Claim Contact: _____ Claim Phone #: _____

Attorney Name: _____ Attorney Phone #: _____

Complaint Information

Injury Occurred: ◯ Automobile ◯ Work ◯ Third-Party ◯ Other Injury Date: _____

Injury Origin: _____

Desc Discomfort: _____

Frequency: ◯ Always ◯ Hourly ◯ Daily ◯ Occasionally

Interfere w/ Activities: ◯ Yes ◯ No Affected Sleep: ◯ Yes ◯ No

Missed Work: ◯ Yes ◯ No Unable to Work from: _____ Unable to Work til: _____

Affected Appetite: ◯ Yes ◯ No Explain: _____

Reduced Work: ◯ Yes ◯ No Explain: _____

Does it Worsen: ◯ Yes ◯ No Explain: _____

Weather Affects it: ◯ Yes ◯ No Explain: _____

Aggravates Condition: _____

Improves Condition: _____

Received Treatment: ◯ Yes ◯ No Explain: _____

X-rays Taken: ◯ Yes ◯ No Explain: _____

Same Condition Before: ◯ Yes ◯ No Date: _____ Practitioner: _____

History

Last Physical Exam: _____ Primary Phys: _____ Phys Phone #: _____

Phys City: _____ Phys State: _____ Phys Zip: _____

Health Conditions: _____

Previous Chiro Care: ◯ Yes ◯ No Date: _____ Explain: _____

Chance Pregnant: ◯ Yes ◯ No Planning: ◯ Yes ◯ No

Medications: _____

Supplements: _____

Broken Bones: ◯ Yes ◯ No Treatment: ◯ Yes ◯ No Explain: _____

Sprains/Strains: ◯ Yes ◯ No Treatment: ◯ Yes ◯ No Explain: _____

Hospitalized: ◯ Yes ◯ No Explain: _____

Surgery: ◯ Yes ◯ No Explain: _____

Auto Accident: ◯ Yes ◯ No Treatment: ◯ Yes ◯ No Explain: _____

Struck Unconscious: ◯ Yes ◯ No Treatment: ◯ Yes ◯ No Explain: _____

Eating Disorder: ◯ Yes ◯ No Explain: _____

Stroke: ◯ Yes ◯ No Explain: _____

Family Health Hist: _____

Patient Social

Alcohol:	◯Daily	◯Weekly	◯Occasion	◯Never	Caffeine:	◯Daily	◯Weekly	◯Occasion	◯Never
Diet Food Products:	◯Daily	◯Weekly	◯Occasion	◯Never	Drugs:	◯Daily	◯Weekly	◯Occasion	◯Never
OTC Stimulants:	◯Daily	◯Weekly	◯Occasion	◯Never	Exercise:	◯Daily	◯Weekly	◯Occasion	◯Never
Homemade Food:	◯Daily	◯Weekly	◯Occasion	◯Never	Processed Food:	◯Daily	◯Weekly	◯Occasion	◯Never
Soft Drinks:	◯Daily	◯Weekly	◯Occasion	◯Never	Tobacco:	◯Daily	◯Weekly	◯Occasion	◯Never
Water:	◯Daily	◯Weekly	◯Occasion	◯Never					

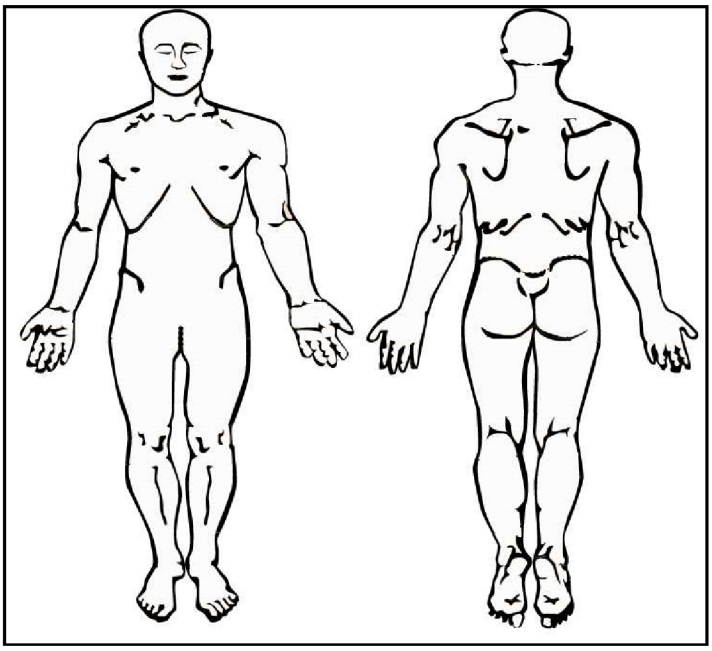
Health Checklist

☐ Allergies	☐ Alcoholism	☐ Anemia
☐ Arteriosclerosis	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Breast Lump	☐ Bronchitis
☐ Bruise Easily	☐ Cancer	☐ Chest Pain
☐ Cold Extremities	☐ Constipation	☐ Cramps
☐ Depression	☐ Diabetes	☐ Digestion Problems
☐ Dizziness	☐ Excessive Menstruation	☐ Eye Pain or Difficulties
☐ Fatigue	☐ Frequent Urination	☐ Headache
☐ Hemorrhoids	☐ High Blood Pressure	☐ Hot Flashes
☐ Irregular Heart Beat	☐ Irregular Menstrual Cycle	☐ Kidney Infection
☐ Kidney Stones	☐ Loss of Memory	☐ Loss of Balance
☐ Loss of Smell	☐ Loss of Taste	☐ Nosebleeds
☐ Pacemaker	☐ Polio	☐ Poor Posture
☐ Prostate Trouble	☐ Sciatica	☐ Shortness of Breath
☐ High Blood Pressure	☐ Sinus Infection	☐ Insomnia
☐ Spinal Curvatures	☐ Stroke	☐ Swelling of Ankles
☐ Swollen Joints	☐ Thyroid Condition	☐ Tuberculosis
☐ Ulcers	☐ Varicose Veins	☐ Venereal Disease

☐ Other: _____

Patient Signature: _____ Date: _____

Patient Symptoms:



I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Wickwire Chiropractic
655 N Center Point Rd
Hiawatha, IA 52233
319-393-3345

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in patient record privacy and a privacy official has been designated to enforce the procedures in our office. We have taken precautions that are known by this office to assure that your records are not readily available to those who don't need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Name of Patient and Signature of Patient or Guardian Date

For further information regarding this notice, please contact our owner Dr. Lee Wickwire at 319-393-3345

INSURANCE POLICY

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

I have read and understand the payment policy of Wickwire Chiropractic and Wellness Center. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Wickwire Chiropractic and Wellness Center and my insurance company. I request that Wickwire Chiropractic and Wellness Center prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at Wickwire Chiropractic and Wellness Center that fees will be due and payable immediately.

_____

Patient's signature (or guardian if patient is a minor) Date

INSURANCE BENEFITS

Patient's Name: _____

1. We have verified your benefits and while your insurance company did not guarantee payment, they stated that you have a $_____deductible. You have $_____remaining until your deductible is met. Additionally, your insurance will pay _____% of covered charges, leaving _____% of each visit due by you.

2. We have verified your benefits and while your insurance company did not guarantee payment, they stated that you have a $_____co-pay due by you each visit.

3. Benefits are available for up to _____ visits per year.

4. Maximum Out of Pocket per year: _____

Insurance Company: _____

Wickwire CHIROPRACTIC and Wellness Center

FINANCIAL POLICY

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

CASH
HEALTH INSURANCE
AUTO ACCIDENT
PERSONAL INJURY
WORKMANS COMP
HSA / HRA
FLEX PLANS
MEDICARE & MEDICAID

"Health insurance has as much to do with being healthy as life insurance has to do with being alive. If you rely on an insurance company's recommended plan for your health care needs, we hope you have good life insurance."

For your convenience we accept cash, check, Mastercard, Visa, American Express, and Discover.

PATIENTS WITHOUT INSURANCE

We request that 100% of the first visit be paid at the time of the visit. On other visits, payment may be made at the end of the week if you sign a credit guarantee form. We are happy to accept cash, check, MasterCard, AMEX, Discover, or Visa.

GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers chiropractic, although many policies do. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays. You may also pay the full amount due each day. You may then submit the bill to your insurance carrier for reimbursement. We accept many insurances including BlueCross BlueShield (except HMO plans), Aetna, Cigna, United Healthcare, Medica, Health Partners, Medicare, and Medicaid. We may accept others listed here if you provide us with your insurance information.

"ON THE JOB" INJURY (Worker's Compensation)

If you're injured at work, your care should be paid for under your employer's Worker's Compensation insurance. You'll need to inform your employer of the accident and obtain the name and address of their insurance. If your employer doesn't provide the information, if a settlement has not been made within 3 months, or if you suspend/terminate care, any fees are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.
4. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to *thirty days* after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

MEDICARE & MEDICAID

Medicare will cover ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services.

Medicaid covers only manual manipulation of the spine and x-rays. All other services we provide are NON-COVERED. See above.

SECONDARY INSURANCE

Please inform us of any secondary insurance you have and we will assist you.

FLEX PLANS / MEDICAL SAVINGS ACCOUNTS / HSA / HRA

Please inform us if you have a medical savings account, sometimes known as a "flex plan". We will be happy to provide you with a statement of your charges for reimbursement.

SERVICE FEE ON RETURN CHECKS

If your check is returned you authorize us to electronically re-deposit your check for the face amount and a $30.00 service fee. You also authorize us to collect the service fee by paper check or demand draft.

Wickwire CHIROPRACTIC and Wellness Center

www.WickwireChiropractic.com
319-393-3345 Hiawatha
319-449-4874 Marion
319-232-5202 Waterloo
319-626-2690 North Liberty