Welcome to Professional Chiropractic Care

Stakes Chiropractic Center
7413 Old Bee Caves Rd., Austin, Texas 78735-8234
Phone: 512/892-2160 Fax: 512/892-7309

Thank you for choosing our office for your chiropractic needs. If you have any questions or concerns, please do not hesitate to ask for assistance. ***Please write legibly*** *so we may process your information correctly.*

Date:

Name: SSN:

Address: City State Zip

Birth date: Age: ☐ Male ☐ Female Home Phone: Cell:

Employer: Occupation: Work Phone:

Personal email: # of Children: Spouse's Name:

Are You: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

(Person to contact in case of emergency)
Name: Relation: Phone:

Nearest Relative not living with you: Relation: Phone:

Whom may we thank for referring you?

Responsible Party:

(if different than patient)
Person responsible for this account:

Relationship to the patient: Birth date: SSN:

Address Phone:

Reason for your visit:

Current symptoms/Major Complaints:

1 ______ 4 ______
2 ______ 5 ______
3 ______ 6 ______

When did you first notice the symptoms?: (If chronic, most recent flare-up)

Was this due to an accident: ☐ Yes ☐ No If yes, was it at: ☐ Home ☐ Work ☐ Automobile

If accident, what was the date of the accident:

Which activities are difficult to perform? ☐ Standing ☐ Sitting ☐ Walking ☐ Bending ☐ Twisting ☐ Lying down ☐ Other______________

Name and phone number of other doctor's who have treated you for this condition?

______

______

Previous Chiropractic Care? (Names/Dates)

______

______

Has any doctor diagnosed you with Hypertension presently: ☐ Yes ☐ No If yes, describe
____

Has any doctor diagnosed you with Diabetes presently : ☐ Yes ☐ No If yes, ☐ Type I ☐ Type II
If yes, was your blood lab work test for hemoglobin A1C greater than 9%? ☐ Yes ☐ No ☐ Not sure

Please list any medications you are currently taking and reasons for. ☐ **Check here if no current medications**

Medication	Reason taking	Dosage/Frequency

Please list any known allergies to medications:
____

If none, check here ☐

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ☐ **Yes** ☐ **No**

Other Health History:

Please list any and all accidents and falls(including auto accidents)

1.______________________ Mo/Yr ________ 3. ______________________ Mo/Yr ______

2. ______________________ Mo/Yr ________ 4. ______________________ Mo/Yr ______

Please list any and all operations/procedures

1.______________________ Mo/Yr ________ 3. ______________________ Mo/Yr ______

2. ______________________ Mo/Yr ________ 4. ______________________ Mo/Yr ______

Please check any other current health conditions

____ Gall Bladder
____ Heart Disease
____ Thyroid
____ Stroke
____ Cancer _______________
____ Prostate
____ Female Organs
____ Anemia
____ Sinus
____ Allergies _______________
____ Appendectomy
____ Stomach
____ Hernia
____ Other (Please list)

Name/number of Primary Care Physician:

HABITS

Do you currently smoke tobacco of any kind?
☐Yes ☐ Former ☐ Never
If current: Packs/Day ___

☐ Alcohol # per Day ___
☐ Caffeine Cups/Day ___

EXERCISE

☐ None
☐ Light Activity
☐ Moderate Activity
☐ Active
☐ Very Active
☐ Elite Athlete

FAMILY HISTORY

	Diabetes	Heart	Kidneys	Cancer
Mother				
Father				
Brother/s				
# of ____				
Sister/s				
# of ____				

The government is requiring us to ask the following questions.

Employment Status: ☐ Employed ☐FT student ☐ PT student ☐ Self-employed ☐ Retired ☐ Other

Race: ☐White ☐Black/African Amer. ☐American Indian/Alaskan Native ☐Native Hawaiian/Other Pacific
☐ Hispanic ☐Asian ☐Chinese ☐Filipino ☐Japanese ☐Korean ☐Vietnamese
☐ Other(specify)______________________________ ☐ I choose not to specify

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I choose not to specify

Preferred Language: ☐ English ☐Spanish ☐Chinese ☐ Vietnamese ☐ **Other** ______________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. Furthermore, I understand that any amount authorized to be paid directly to the Doctor's Office from the insurance company will be credited to my account on receipt. I also understand that if I suspend or terminate my care at this office, any outstanding charges for services or products rendered me will be immediately due and payable. If I fail to take care of such outstanding charges within 30 days from my last treatment, I understand I will be responsible for any and all fees incurred in the outside collections of this account, These, but not limited to these include court cost, attorney fees and collections agencies.

Patient's/Guardian's Signature X________________________________ Date: ____________

Driver's License # ________________________ State _____

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, ________________________________, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

____

Signature Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the Acknowledgment**
- ☐ **An emergency situation prevented us from obtaining Acknowledgment**
- ☐ **Other (Please Specify)** ____

____

____

Staff signature **Date**

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Below are a list of diseases which may seem unrelated to the purpose of your appointment However, these questions must be answered carefully as these problems can effect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorder
- ☐ Lumbago
- ☐ Eczma

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE LAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

FEMALES ONLY:

When was your last period? ________

Are you pregnant?

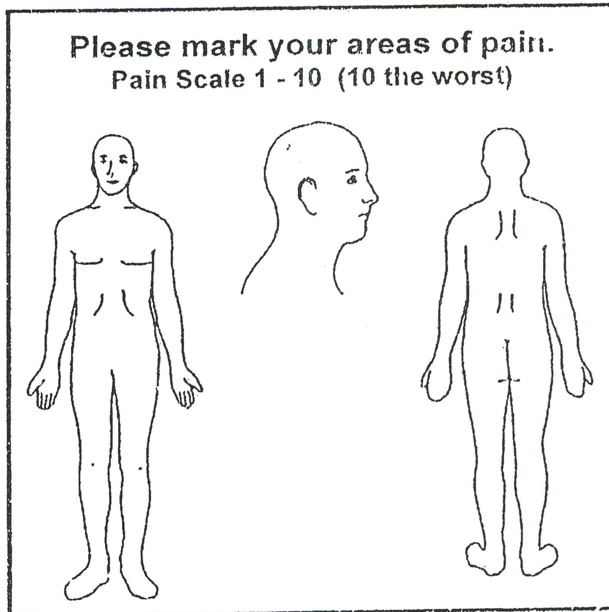
☐ Yes ☐ No ☐ Not Sure

NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke



GENERAL CODE

- ☐ Fatique
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

MALE/FEMALE CODE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain/Infections
- ☐ Breast Pain/Lumps
- ☐ Prostrate/Sexual Dysfunction

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA | CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED X DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED X

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ___ . ___ 3. ___ . ___

2. ___ . ___ 4. ___ . ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

790-0129 (08-05) (OCR) 1PT.