KING of PRUSSIA
family wellness center

Welcome to our office!

PATIENT INFORMATION

Today's Date: ____________________________
Patient Name: ____________________________
Sex: Male Female
Marital Status: Single Married Other
Birth Date: ____________________________
Address: ____________________________
City: ____________________________
State: ____________________________
Zip: ____________________________
Email address: ____________________________
**We send appointment reminders via email or text*
Home Phone: ____________________________
Cell Phone: ____________________________
Work Phone: ____________________________
Which is the best number to reach you? ____________
Spouses Name: ____________________________
Children names/ages: ____________________________
____

Occupation: ____________________________
Employer/School: ____________________________
Address: ____________________________
Office Phone: ____________________________

How were you referred to our office?
____

IN CASE OF EMERGENCY, CONTACT

Name: ____________________________
Phone: ____________________________
Relationship: ____________________________

May we have your permission to update your medical doctor regarding your care at this office? Yes No
Family Doctor: ____________________________
Address: ____________________________
City/State/Zip: ____________________________
Phone: ____________________________

INSURANCE INFORMATION

Primary Insurance Company: ______________________
Subscriber's Name: ______________________
Subscriber's Birth date: ______________________
Relationship to patient: ______________________

AUTHORIZATION AND RELEASE

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

____
Signature of Patient, Parent, or Guardian

____
Printed name of Patient, Parent, or Guardian

Date: ______________________________________

ACCIDENT INFORMATION

Is your current condition due to an accident? Yes No
Date of accident: ____________________________________
Type of accident: Auto Work Other
To whom have you made a report of this accident?
Auto Insurance Worker's Comp Other
If an auto accident, please provide:
Insurance company: ______________________________
Claim number: ______________________________
Contact person: ______________________________
Phone: ______________________________
Attorney contact info: ______________________________
(if applicable) ______________________________
____

What brings you to our office? ________________________________
____

How did you hurt yourself? UNKNOWN or _______________________
____

On a scale of 1-10 (10 being the worst) please rate your pain. ________

How long have you had it?
____

Circle the quality: Dull / Sharp / Aching / Burning / Shooting / Tightness / Stiffness / Numbness

What makes it worse? ____

What makes it better? ____

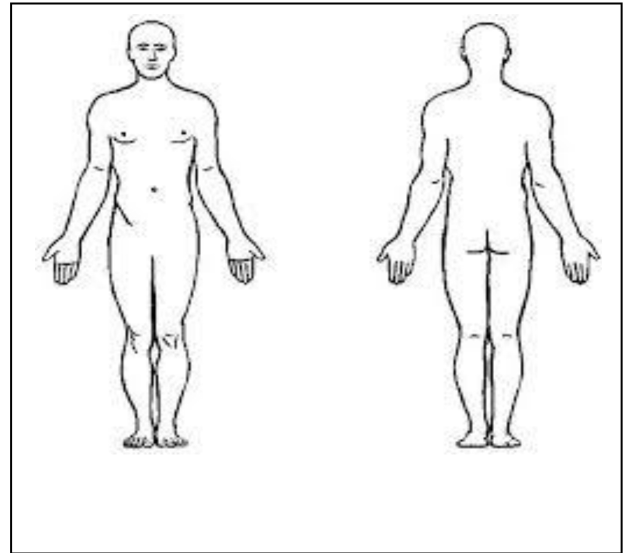
Ever have it this bad before? ___________ If so, when? ____________

Who have you already seen for this? ____________________________

What have you already tried? __________________________________

Have you ever been to a chiropractor? Yes / No
Do you have any other physical complaints we may help you with?
____

Please mark on this where your problem areas are:



What are you unable to do because of this that you would really like to do easily and pain-free again? ______________________________
____

Please circle any conditions or symptoms that are affecting you now or have in the past.			Demographics, Past Medical History, Social History
MUSCULOSKELETAL osteoporosis arthritis scoliosis neck pain back problems hip disorders knee injuries foot/ankle pain shoulder problems elbow/wrist pain TMJ issues poor posture	**CARDIOVASCULAR** chest pain palpitations dizziness dyspnea hypertension hypotension high cholesterol excessive bruising lower extremity bruising	**GENITOURINARY** dysuria urinary frequency urgency incontinence blood in the urine	**How tall are you?** ___________________ **How much do you weigh?** ____________ **What is your shoe size?** _________ **Wide? Y / N** **Is there a chance you are pregnant? Yes/ No Due Date:** ______________ **When is the last time you have had x-rays?** _______________________________________ **Of what?** _______________________________
NEUROLOGICAL/PSYCH anxiety depression memory issues sleeping issues headaches dizziness pins and needles numbness loss of smell or taste	**ESPIRATORY** cough shortness of breath asthma apnea emphysema hay fever pneumonia wheezing	**ENDOCRINE** diabetes heat or cold tolerance hyperthyroidism hypothyroidism inc. in size of hands & feet pancreatic conditions polyuria (excessive urination) polydypsia (excessive thirst) purple striae (stretch marks)	**Have you had any surgeries?** _______________________________________ **Are you on any medications?** _______________________________________ **Have you had any recent illnesses?** _______________________________________ **Any recent accidents:** _______________________________________
HEENT blurred vision earache recent hearing loss ringing in the ears chronic ear infections hoarseness sore throat difficulty swallowing	**GASTROINTESTINAL** nausea vomiting abdominal pain heartburn ulcer food sensitivities changes in bowel habits constipation diarrhea blood in stool	**DERMA/HEMA** new rashes easy bruising gum bleeding blood with stools hyper/hypopigmentation excessive acne eczema psoriasis skin cancer	**Work: ___ FT ___PT ___UNEMPLOYED ___STAY AT HOME** **Alcohol: No or Yes - Drinks in a week?** __________ **Caffeine: No or Yes - How many cups a day?** _____ **Tobacco: No or Yes - How many packs a day?** ____ **Recreational Drugs: Yes or No** **Exercise: Yes or No - Times in a week:** ________ **Diet ____Normal (3 meals a day)Restricted?** ______ ____ **Supplements/Vitamins?**________________________ ____ ____ ____

King of Prussia Family Wellness Center

FAMILY HEALTH HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of any immediate family member. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	***FAMILY MEMBER***	***FAMILY MEMBER***	***FAMILY MEMBER***
Arthritis			
Asthma			
Back trouble			
Bursitis			
Cancer			
Constipation			
Diabetes			
Disc Problem			
Emphysema			
Epilepsy			
Headaches			
Heart Trouble			
High Blood Pressure			
Insomnia			
Kidney Trouble			
Liver Trouble			
Migraine			
Nervousness			
Neuritis			
Neuralgia			
Pinched Nerve			
Scoliosis			
Sinus Trouble			
Stomach Trouble			
Other:			

If any of the above family members are deceased, please list their age at death and cause: ________________________
____

I certify the information provided is accurate to the best of my knowledge.

Name of Patient: ____

Signature of Patient/Legal Guardian: ____

Date: ____

King of Prussia Family Wellness Center

Patient Acknowledgement and Receipt of
Notice of Privacy Practices Pursuant to HIPAA and
Consent for Use of Health Information

Patient's Name____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _______ day of _______________________, 20___

By _____________________________________
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By ______________________________________
Signature of Parent/Guardian (circle one)

King of Prussia Family Wellness Center
PATIENT POLICIES

Thank you for choosing King of Prussia Family Wellness Center as your health care provider! We are committed to the success of your treatment. The following are statements of our Patient Policies which we require you to read and sign prior to any treatment.

All patients must complete our Patient Information, Patient Policies, and Patient Health Information Consent 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.

INFORMED CONSENT FOR CHIROPRACTIC CARE ________ Patient's Initials

A patient, in coming to the Chiropractic Doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he or she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he or she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Doctor. The Chiropractor provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by the doctors at King of Prussia Family Wellness Center, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

APPOINTMENT SCHEDULING _________ Patient's Initials

Please help us serve you better by keeping scheduled appointments. We charge a $25 missed appointment fee for repeat offenders. 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 requirements is for this clinic to develop a treatment program that is oriented toward improving your level of functionality to your maximum potential. Our ability to assist you with meeting these goals is 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. If you are non-complaint with your ordered treatment plan you will be discharged from that plan. If this is the case, you will be offered maintenance treatment on a schedule that you can determine. This type of treatment however is not a covered benefit under insurance plans and we will not bill these services to your carrier. Payment for this type of treatment will be your responsibility.

ASSIGNMENT OF INSURANCE BENEFITS _________ Patient's Initials

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from King of Prussia Family Wellness Center is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 90 days and you refuse to assist us in dealing with your carrier, the balance will be automatically payable by you.

****** PLEASE COMPLETE OTHER SIDE ******

PATIENT POLICIES continued

Informing us immediately of any change in your coverage is vital to this office being able to process claims promptly. If your insurance changes, you suffer a work related injury, or are in an automobile accident, our office must be notified before your next appointment. ***If our office is not provided with your insurance coverage before your appointment, visits will be charged cash patient fees until this information is provided.***

REGARDING DEDUCTIBLE AND CO-INSURANCE/CO-PAYMENT OBLIGATIONS _________ Patient's Initials

By law we are required to make reasonable efforts to collect deductibles and co-insurance and/or co-payment obligations. 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 bill for all co-insurance, co-payment and deductible amounts. 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 _________ Patient's Initials

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. 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/Medicade Services (CMS) formerly known as HCFA. Not all carriers utilize CMS RUV's when determining their allowances of service. Many carriers implement an arbitrary schedule of allowances. This clinic will accept your carrier's allowance as your payment as full 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 EOB. This statement does not mean that we accept the carrier'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.

NON-COVERED SERVICES _________ Patient's Initials

Your treatment may involve services that are not covered under your health benefit plan. You have the right to deny receipt of these services. If you elect to receive any or all services recommended, you will be fully responsible for payment of these services. We make every attempt to verify the limitations of your health insurance benefit plan. 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 upon your benefit contract.

WORKERS COMPENSATION AND PERSONAL INJURY _________ Patient's Initials

Worker's Compensation and Personal Injury usually pays at 100% for Chiropractic Care.

Upon being released from care, a 3-month time period is allowed for settlement of your claim. If settlement has not been reached within this time period, or if you have suspended or terminated your care without your doctor's approval, payment for service is due immediately. If an attorney is handling your case, please notify the insurance department at once. **Although you are ultimately responsible for your bill, our office will wait for settlement to be paid as long as you are an ACTIVE patient. If you suspend or terminate your care, any fees for services are due immediately.**

BY MY SIGNATURE BELOW, I STATE THAT I HAVE READ AND UNDERSTAND THE POLICIES OF THIS OFFICE AND AGREE TO ABIDE BY THEM.

____ ________________

Patient Name **Date**

____

Patient Signature

King of Prussia Family Wellness Center, PC

WHAT TO EXPECT AFTER YOUR FIRST ADJUSTMENT

Please read the following information carefully and

let us know if you have any questions!

1. If you have never been adjusted, or if it has been awhile since your last adjustment, you may experience soreness or discomfort for a few hours to a few days. This is a normal reaction to chiropractic adjustments, as your body may have had restricted motion for a while and is now getting used to movement again.

2. If you are sore, use ice packs on the affected area. Ice therapy consists of the use of ice packs at 20-minute intervals followed by 40 minutes of rest. This can be repeated as often as needed. Do not apply ice directly to bare skin. Always protect skin with a thin covering such as a shirt or light towel. Cover the ice pack with a thick towel to retain the cold.

3. **Do not use heat** except under the doctor's instruction. Heat may aggravate your injury.

4. Avoid heavy lifting or repetitive movements until the doctor indicates you are ready for normal activities. Strenuous athletic activities such as running, lifting weights, impact aerobics, racquetball, tennis, skiing, bowling, etc. should be avoided. Other things to avoid are yard work such as raking, digging, lifting heavy objects such as groceries, pets and children, and any other activities that could aggravate or re-injure your condition.

5. Unless indicated by the doctor, you may return to work/school after your appointment.

6. If a sudden movement causes sharp or severe pain, or if you experience swelling, contact us at 610-337-7463.

I, ___________________________________, have read and understand the directions for my follow-up care.

Patient Signature _______________________________________ Date _______________