Dr.10's Chiropractic Center LLC

Welcome to our office!

Dr. Shan Tian, D. C.

Patient Information

Please complete all questions.

Today's Date: _____

Name: _____

Street: _____ Apt# _____

City: _____ State: _____ Zip: _____ Social Security #: _____

Birth Date: _____ Sex M ___ F___ Single ___Married ___Divorced ___Widowed ___Separated___

Email Address: _____ Home Phone: _____ Cell/Other Phone: _____

___Employed ___Full-Time Student ___Part-Time Student ___ Retired Patient's School Name _____

Patient Employer: _____ Occupation: _____

Work Address: _____ Work Phone: _____

Name of spouse _____Spouse's Employer: _____

Names and Ages of Children _____

Who may we thank for referring you to our office? _____

In Case of Emergency, who should be notified? _____

Relationship to patient: _____ Phone: _____

INSURANCE INFORMATION

Responsible Party (if different from patient): _____

Relationship to Patient: _____ Birth Date: _____ Social Security#: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Responsible Party Employer: _____ Work Phone: _____

Name of Insurance Company: _____ Phone: _____

Group/Policy#: _____ Contract/Subscriber#: _____

Have you ever seen a chiropractor before? ____Yes ____No If so, when was last visit? _____

Family Medical Doctor: _____

Address: _____ Phone: _____

What surgeries have you had if any?

1) _____ When? _____

2) _____ When? _____

3) _____ When? _____

Patient Name _____

Have you experienced any of the following? Please circle yes or no. If yes, explain on the line following. If you need more room, please use the back of this form.

1. Falls _____ Yes No
2. Sports injuries? _____ Yes No
3. Broken bones? _____ Yes No
4. Auto accidents? _____ Yes No

When? Any injuries? _____

FAMILY/MEDICAL HISTORY

Father: Deceased? NO YES If yes, Cause of Death: _____

Mother: Deceased? NO YES If yes, cause of Death: _____

Brothers/Sisters: How many? _____ significant health problems? _____

Are you taking any medications? Please list. _____

_____

Are you now or have you suffered from any of the following? ___ Cancer ___ Stroke ___ Sinus ___ Shingles ___ Fatigue ___ Migraine/Headache ___ Dizziness ___ Anxiety ___ Fainting ___ Heart Problems ___ Respiratory Problems ___ Diabetes ___ Numbness ___ Arthritis ___ High Blood Pressure ___ Psychological Problems ___ Other_____

Pregnancy Release: This is to certify that to the best of my knowledge, I am not pregnant and the above doctor and her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Signature _____ Date_____

Consent to treat a minor child: I hereby authorize this office to administer chiropractic as deemed necessary for my child.

Signature _____ Date_____

Not all patients require x-rays to determine or verify a diagnosis, type of treatment or length of treatment; if your examination warrants x-ray analysis, the fees paid for x-rays is for analysis only and the film itself is the property of this office and must remain part of your permanent patient record.

ALL FIRST VISIT CHARGES ARE PAYABLE WHEN SERVICES ARE RENDERED. I CLEARLY UNDERSTAND AND AGREE THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

I have read and completed the above information.

Signature_____ Date_____

Dr.10's Chiropractic Center LLC

Name: _____ Date: _____

Please tell us about your pain.

List the problem area(s) separately and answer the following questions regarding your affected area(s).

Problem 1: _____Started when? _____

How often is problem present? Constant frequent occasional seldom

Quality of Pain? dull aching sharp shooting burning throbbing deep nagging other _____

Have you had your main problem before? Yes No If yes, when? _____

Rate the pain from 1 to 10 (1 is little or no pain, 10 is severe pain) 1 2 3 4 5 6 7 8 9 10

Other Information: _____

_____

Problem 2: _____ Started when? _____

How often is problem present? Constant frequent occasional seldom

Quality of Pain? dull aching sharp shooting burning throbbing deep nagging other _____

Have you had your main problem before? Yes No If yes, when? _____

Rate the pain from 1 to 10 (1 is little or no pain, 10 is severe pain) 1 2 3 4 5 6 7 8 9 10

Other Information: _____

_____

Problem 3: _____ Started when? _____

How often is problem present? Constant frequent occasional seldom

Quality of Pain? dull aching sharp shooting burning throbbing deep nagging other _____

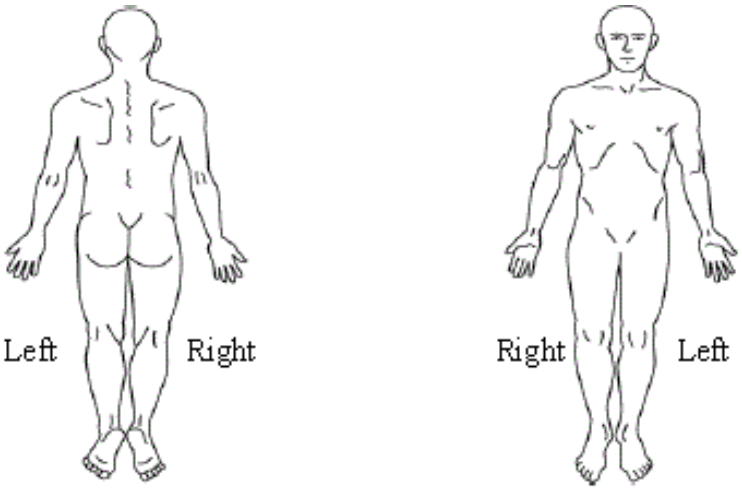
Have you had your main problem before? Yes No If yes, when? _____

Rate the pain from 1 to 10 (1 is little or no pain, 10 is severe pain) 1 2 3 4 5 6 7 8 9 10

Other Information: _____

_____

Mark the areas of pain on the figures below. Include all affected areas. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels.



Dr.10's Chiropractic Center LLC

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 will suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

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 arrangements are made with the staff. No exceptions will be made unless you sign a credit guarantee form, or if the doctor or office manager approves another arrangement. We are happy to accept your check, Master Card 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 most policies do provide coverage. 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 noncovered services, deductibles or co-pays

MEDICARE

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover, which for Chiropractors is ONLY manual manipulation of the spine, also known as an adjustment. 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, modalities (i.e. electrical stimulation or ultrasound), 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. Our office will complete and file the forms for Medicare at no charge.

SECONDARY INSURANCE/ FLEX PLANS/MEDICAL SAVINGS ACCOUNTS

Please inform us of any secondary insurance or other plan you may have. We will file or assist you if you need help in filing, and/or provide you with a statement of your charges for reimbursement.

OTHER INSURANCE (e.g. Auto insurance, Property Insurance, etc.)

If your care is to be paid by an insurance company, other than health insurance, we will bill that insurance for your care as a courtesy to you. In order to do so, we require confirmation from the insurance company. This confirmation must include coverage information, including any limitations and billing specifications. Although you are ultimately responsible for your bill, we will wait for payment of your treatment for up to 3 (three) months after your care is completed.

INSURANCE FORMS/PAYMENT

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 Dr. 10's Chiropractic Center. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Dr. 10's Chiropractic Center and my insurance company. I request that Dr. 10's Chiropractic 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, if I suspend or terminate my schedule of care as prescribed by the doctors at Dr. 10's Chiropractic Center, or if my insurance coverage is suspended or terminated, that fees will be due and payable immediately.

_____

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

_____

Witness

SPECIAL PAYMENT INSTRUCTIONS

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, $_____of which has been met. Additionally, your insurance will pay _____% of covered charges, leaving _____% of each visit due by you. You have a maximum benefit of _____ visits or $_____ per benefit period.
2. We have verified your benefits and while your insurance company did not guarantee payment, they stated that you have a $_____deductible, $_____of which has been met. Additionally, your insurance will pay _____% of covered charges, leaving $_____co-pay of each visit due by you. You have a maximum benefit of _____ visits or $_____ per benefit period.

Dr.10's Chiropractic Center LLC

Terms of Acceptance:

1. If Dr. 10, during the course of chiropractic spinal exam, discovers non chiropractic, or unusual findings, she will advise you. If you desire advice, diagnosis, or treatment for these findings, we recommend that you seek the services of a health provider who specializes in that area.

2. Our only practice objective is to eliminate major interference to the expression of the body's innate wisdom. Our only method is the specific adjusting to correct vertebral subluxations.

3. Shan Tian DC (Dr. 10) does not offer to treat or diagnose any condition other than vertebral subluxation. Dr. 10 uses a semi-open adjusting area. It is understood that this does not provide guaranteed privacy, but the patients are always clothed. If you wish to discuss private issues with Dr. 10, request a consultation in the doctor's private consultation areas.

Is this OK with you?	**Y/N**
May we telephone you?	**Y/N**
Leave a message on your answering machine?	**Y/N**
Send you mail?	**Y/N**
May we discuss your case with your spouse?	**Y/N**

Your appointment time is saved specially for you. If you cannot be on time, we request a telephone call from you so we can serve other patients. If you are late, we will work you in as best we can, but on time patients deserve priority to be seen at their promised times. We are very serious about your care. If you are not equally serious, it may be necessary for us to discontinue your care after discussing your priorities with you

.

Patient Signature _____ Date_____

Witness Signature _____ Date _____