

CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____
SS/HIC/Patient ID # _____
Patient Name _____
Last Name _____
First Name _____ Middle Initial _____
Address _____
E-mail _____
City _____
State _____ Zip _____
Sex M F Age _____
Birthdate _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years
Patient Employer/School _____
Occupation _____
Employer/School Address _____
Employer/School Phone (_____) _____
Spouse's Name _____
Birthdate _____
SS# _____
Spouse's Employer _____
Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Co. _____
Group # _____
Is patient covered by additional insurance? Yes No
Subscriber's Name _____
Birthdate _____ SS# _____
Relationship to Patient _____
Insurance Co. _____
Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. **JOSEPH S. FEREZY** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date

Relationship to Patient

3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? Yes No Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____

5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

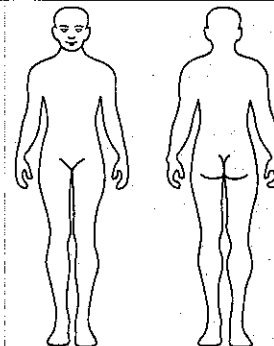
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down



6 HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery Physical Therapy

Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | | | | | |
|---------------------|--|------------------|--|---------------------|--|----------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chicken Pox | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergy Shots | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Miscarriage | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anorexia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fractures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Suicide Attempt | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Appendicitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple Sclerosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Goiter | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gonorrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors, Growths | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast Lump | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Typhoid Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pinched Nerve | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bulimia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumonia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vaginal Infections | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herniated Disk | <input type="checkbox"/> Yes <input type="checkbox"/> No | Polio | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate Problem | <input type="checkbox"/> Yes <input type="checkbox"/> No | Whooping Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthesis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____ | |
| | | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | |

EXERCISE

- None
 Moderate
 Daily
 Heavy

WORK ACTIVITY

- Sitting
 Standing
 Light Labor
 Heavy Labor

HABITS

- Smoking
 Alcohol
 Coffee/Caffeine Drinks
 High Stress Level

Packs/Day _____
 Drinks/Week _____
 Cups/Day _____
 Reason _____

Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

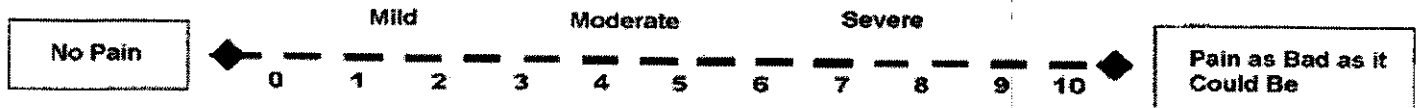
7 MEDICATIONS ALLERGIES VITAMINS/HERBS/MINERALS

_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (_____) _____	_____	_____

“TELL US WHY YOU ARE HERE”

Please mark below any final comments about your health or condition that you would like the doctor to know and consider. Grade your pain on the scale, and answer the questions below to the best of your ability. Please try to answer all of the questions.

Rate the Severity of Your Pain (If Any):



Pain intensity: 0.No pain 1.Mild pain 2.Moderate pain 3.Severe pain 4.Worst possible pain

Sleeping: 0.Perfect sleep 1.Mildly disturbed sleep 2.Moderately disturbed sleep 3.Greatly disturbed sleep 4.Totally disturbed sleep

Personal care (washing, dressing, etc.): 0. No pain/no restrictions 1.Mild pain/no restrictions 2.Moderate pain/need to go slowly 3.Moderate pain/need some assistance 4.Severe pain/need 100% assistance

Travel (driving, flying, etc.): 0.No pain on long trips 1.Mild pain on long trips 2.Moderate pain on long trips 3.Moderate pain on short trips 4.Severe pain on short trips

Work: 0. Can do usual work plus unlimited extra work 1.Can do usual work/no extra work 2.Can do 50% of usual work 3.Can do 25% of usual work 4. Cannot work

Recreation: 0.Can do all activities 1.Can do most activities 2.Can do some activities 3.Can do a few activities 4.Cannot do any activities

Frequency of pain: 0.No pain 1.Occasional pain 25% of the day 2.Intermittent pain 50% of the day 3.Frequent pain 75% of the day 4.Constant pain 100% of the day

Lifting: 0.No pain with heavy weight 1.Increased pain with heavy weight 2.Increased pain with moderate weight 3.Increased pain with light weight 4.Increased pain with any weight

Walking: 0.No pain any distance 1.Increased pain after one mile 2.Increased pain after one half-mile 3.Increased pain after one quarter-mile 4.Increased pain with all walking

Standing: 0.No pain after several hours 1.Increased pain after several hours 2.Increased pain after one hour 3.Increased pain after one half-hour 4.Increased pain with any standing

Signature

Date

PATIENT CONSENT FORM

DR. JOSEPH S. FERREZY

CHIROPRACTIC NEUROLOGIST

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

FINANCIAL POLICY FOR THE OFFICE OF DR. JOSEPH S. FERZY

NOTE: ALL PATIENTS MUST COMPLETE OUR INFORMATION AND INSURANCE FORM BEFORE SEEING A HEALTH CARE PROVIDER.

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill must be made at the time of your treatment unless other arrangements have been made. The following is a statement of our Financial Policy, which we require that you read, and sign prior to treatment.

INSURANCE

This office accepts assignment for many indemnity insurance plans, HMO's and PPO's. Please refer to your policy for specifics on charges that are or are not covered. **All co-payments, coinsurance and deductibles are due at the time of service.** We may bill all insurance companies as a courtesy to you if current insurance information is provided. Your insurance policy is a contract between you and your insurance company. We are not a party to that (these) contract(s). If your insurance company or you have not paid for your services within **90 days**, an outside collection agency may be utilized. Monthly payments may be arranged. Please contact our office at **515-440-2005** regarding any questions on your billing between the hours of 8:00 a.m. and 3:30 p.m.

USUAL AND CUSTOMARY RATES

This office is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MISSED APPOINTMENTS

Please help us serve all our patients better by keeping scheduled appointments. If you find it necessary to cancel, please contact our office as soon as possible by phoning **515-440-2242**. **Repeat missed appointments (more than 2) may result in a \$75.00 charge to you not your insurance carrier.** This charge can be avoided by canceling at least 8 hours in advance. Leaving a message with the answering service will satisfy this requirement.

INTEREST CHARGES

Your account may be charged interest at the rate of 1.5% per month or 18% annually for services over 60 days old.

SERVICE FEE ON RETURN CHECKS

A service fee of **\$30.00 or 5% of the face amount** up to \$50.00 will be charged on all returned checks. You may be sued for damages of three times the amount of the check, up to a maximum of \$500.00 pursuant to **Iowa codes 554.3512 & 554.3513**. Return checks will be electronically re-deposited for the face amount and service fee. The service fee may also be collected by paper draft, CBSI Oskaloosa, Iowa or servicing agency.

TIME OF SERVICE DISCOUNT

We offer a 20% discount for payment in full at the time of service.

Thank you for reviewing our Financial Policy. It is the goal of this office to provide quality care at a reasonable cost. By adhering to our policy, this can be achieved. Please let us know if you have any questions or concerns.

I have read, understand and agree to the Financial Policy. I further authorize release of necessary medical records to my insurance carrier and direct payment to the provider of care.

_____ Date

Signature of patient or legal guardian for person receiving care