Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

NAME _____ DATE _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ WORK PHONE _____

DATE OF BIRTH _____ AGE _____ M _____ F _____ MARITAL STATUS _____ NO. OF CHILDREN _____

OCCUPATION _____ SS# _____ SPOUSE _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____ REFERRED BY _____

Name of Policy Holder: _____

Policy holders DOB _____ EMAIL: _____

CHIEF COMPLAINT

Exact Description _____

Related to Fall or Accident _____

Onset _____ Reoccurrence _____ Progress: Worse Same Better

PREVIOUS MEDICAL CARE FOR CHIEF COMPLAINT

Name and Location of Doctor _____

Date Attended _____ Hospital _____

Examination and X-Rays Made _____

Condition or Diagnosis _____

Type of Treatment _____

Results of Treatment: Good Fair Poor _____

SECONDARY COMPLAINT

Condition _____

Onset _____ Becoming: Worse Same Better

Name of Doctor _____ Date of Care _____

Type of Treatment: Good Fair Poor _____

OTHER COMPLAINTS

Condition _____

Onset _____ Becoming: Worse Same Better

Name of Doctor _____ Date of Care _____

Type of Treatment: Good Fair Poor _____

PAST HISTORY

Recent Surgery _____

Present or Recent Treatment for Other Conditions _____

Previous Serious Illness _____

Date of Last Physical Examination _____ Doctor _____

What prompted Physical Examination? _____

Results of Examination _____

Present Family Doctor _____

Suburban Chiropractic Clinic

22701 GREATER MACK • ST. CLAIR SHORES, MI 48080 • (586) 777-6056

ASSIGNMENT OF PAYMENT

I hereby authorize and direct my attorney and/or insurance company to directly pay the Suburban Chiropractic Clinic any monies due on my account. This payment shall be made first before all other payments or obligations. The monies for this payment shall be deducted from any settlement made on my behalf.

Further, I agree to personally pay the Suburban Chiropractic Clinic in difference, if any, between the total amount of the charges and the total amount paid by the attorney and/or insurance company.

Further, I agree to personally pay the Suburban Chiropractic Clinic the full amount of the charges should my condition be such that treatment for it is not covered by an insurance policy, or if for any reason the insurance company refuses to pay the claim.

NAME _____ ADDRESS _____

INSURANCE COMPANY _____

SIGNATURE _____ DATE _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Suburban Chiropractic Clinic to release any information acquired in the course of my examination or treatment to any insurance company, attorney or other doctor.

SIGNATURE _____ DATE _____

AUTHORIZATION FOR TREATMENT

I hereby expressly authorize the Suburban Chiropractic Clinic to perform any and all acts within the lawful scope of Chiropractic which in the sole discretion of the chiropractor would be beneficial for my case.

SIGNATURE _____ DATE _____

PREGNANCY FORM

I verify that my last menstrual period was _____ and that I am not pregnant. The Suburban Chiropractic Clinic has been informed of my condition and are not responsible for any future condition as a result of diagnostic x-rays taken on _____.

SIGNATURE _____ DATE _____

X-RAY TECHNICIAN _____ DATE _____

CONSENT TO TREAT A MINOR CHILD

I hereby authorize the Suburban Chiropractic Clinic to tender any for of treatment of Chiropractic as permitted by law and which in their sole discretion would benefit _____, a minor child.

PARENT OR GUARDIAN _____ DATE _____

FEES FOR X-RAYS

I hereby acknowledge that I have been informed that if x-rays are necessary, that there will be a fee charged for those x-rays.

SIGNATURE _____ DATE _____

NOTICE TO OUR PATIENTS

Our office is participating with the following Insurances listed below:

BLUE CROSS/BLUE SHIELD

MEDICARE

MEDICAID

MOST INDEPENDENT INSURANCES

Although we are participating, you will be held responsible for all copays, deductibles and / or charges not covered by your insurance.

We are non-participating with all other carriers, in this instance you will be held responsible for any and all charges remaining after your insurance has paid their portion.

We cannot be held responsible for monitoring your Insurance, It is your responsibility to know your policy participation and non-participation responsibilities of your policy. Please contact your Insurance company if you have any questions regarding your obligations to your carrier, or your questions regarding your policy coverage.

Signature_____

Date_____

Suburban Chiropractic Clinic

Suburban Chiropractic Clinic

Patient-Provider Partnership Agreement

The health and wellness of our patients is a top concern of this office. Providing the best possible care to every patient is our primary goal. The only way we can meet this goal is if I, *your doctor*, and you, *my patient*, work together. This concept is called the Patient Centered Medical Home.

As our patient, your responsibilities are:

- Ask questions, share your feelings and be part of your care
- Be honest about your history, symptoms and other important information about your health
- Tell your healthcare team about any changes in your health and wellbeing
- Take all of your medicine and follow your doctor's advice
- Make healthy decisions about your daily habits and lifestyle
- Prepare for and keep scheduled visits or reschedule visits in advance whenever possible
- Call us *first* with all problems, unless it is a medical emergency
- End every visit with a clear understanding of your doctor's expectations, treatment goals, and future plans

As your provider office, our responsibilities are:

- Explain diseases, treatments, and results in an easy-to-understand way
- Take time to listen to your feelings and questions and help you make decisions for your care
- Keep your treatments, discussions and records secure
- Provide 24-hour access to medical care and same day appointments, whenever possible
- Provide instructions on how to meet your health care needs when the office is not open
- To care for you to the best of my abilities based on my understanding of current medical methods available
- Provide you with clear directions about medicines and other treatments
- When necessary, direct and coordinate your care through referrals to specialists and community resources
- End every visit with clear instructions about expectations, treatment goals, and future plans

Thank you,

Edward Frattini, DC
Patient signature:_____

SUBURBAN CHIROPRACTIC CLINIC
22701 Greater Mack
St. Clair Shores, Michigan 48080
Telephone:(586) 777-6056

To insure our patients privacy, we do not give out any patient information in writing, over the phone or personally to anyone without the consent of our patients per incident. We do not sell names or addresses of our patients.

We do send our insurance claim forms, bill electronically, send our recall cards, Birthday cards, Occasionally holiday cards, statements, thank you cards and welcome to our practice cards.

I _____, Fully understand the above information and accept the policies of this office.

Suburban Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

_____
Name of Patient or Personal Representative

_____ _____
Signature of patient or Personal Representative Date