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_____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Telephone _____ Work Telephone _____

Email Address _____ Fax # _____ Pager _____

Age _____ Birthdate _____ # Children _____

Marital Status: M S W D Occupation: _____

Spouse's Name _____ Spouse's Office Telephone _____

Referred by _____ Nearest Relative & Telephone _____

HEALTH INFORMATION: Have you had previous chiropractic care? _____

What is your major complaint? _____

_____

Other Complaints: _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes ☐ No ☐ Constant ☐ Comes and goes ☐

Is this condition interfering with you: Work ☐ Sleep ☐ Daily routine ☐ Other _____

How long has it been since you really felt good? _____

Other doctors who treated this condition_____

_____

List surgical operations and years:_____

_____

Drugs you now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ "Pep" pills ☐ Tranquilizers

☐ Insulin ☐ Birth control pills ☐ Others _____

Age of mattress____ ☐ Comfortable ☐ Uncomfortable

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner Soles ☐ Arch supports

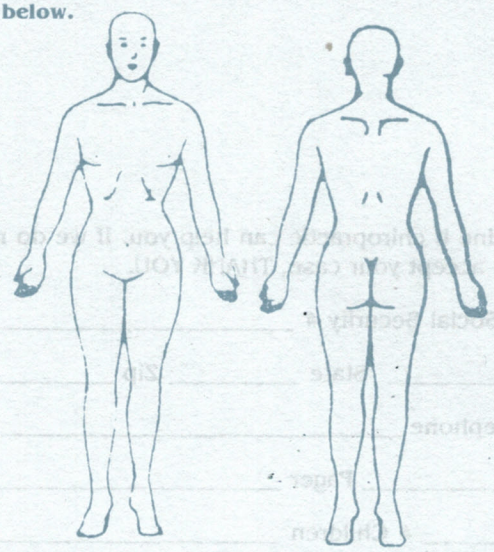
Have you been in an auto accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Describe:_____

Have you had any other personal injury or accident?	☐ Past year	☐ Past 5 years	☐ Over 5 years
	☐ None		

Describe: _____

Please mark your areas of pain on the figure below.



Have You Ever Suffered From:

1. Dizziness_____
2. Backaches_____
3. Heart Trouble_____
4. Diabetes_____
5. Arthritis_____
6. Headaches_____
7. Asthma_____
8. Neuritis_____
9. Digestive Disorders_____
10. Nervousness_____
11. Sinus Trouble_____
12. Neck Pain_____

INSURANCE INFORMATION:

Is your condition due to an auto accident or job related injury? Yes ☐ No ☐

Do you have Health Insurance? Yes ☐ No ☐

If Yes, Name of Company? _____ Policy# _____

Are you covered by Medicare? Yes ☐ No ☐

If Yes, Health Insurance # _____

I understand and agree that health and accident policies are an arrangment between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare an necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon recepit. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered mewill be immediately due and payable.

I will be paying today by ☐ Cash ☐ Check ☐ Credit Card

☐ Mastercard ☐ Visa ☐ Discover

Copay is due at the time services are rendered.

All accounts not paid within 90 days will automatically be put through on your credit card.

Patients Signature: _____ Date_____

Guardian or Spouse's Signature: _____ S.S.#_____

Doctor's Signature: _____

FAMILY HEALTH INFORMATION. (Many health problems are the result of hereditary spinal weaknesses; thus information abot your family members will give us a better picture of your total health picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

King Chiropractic, P.C.

SPORTS, SPINAL AND ORTHOPAEDIC DISORDERS

Dr. L. Neil King
FOUNDER – 1984

Dr. Kelly C. Groves
CHIROPRACTIC DIRECTOR

Dr. Mark Alexander
DOCTOR OF CHIROPRACTIC

Dr. Andrew Vaky
DOCTOR OF CHIROPRACTIC

Linda Reed
PRACTICE ADMINISTRATOR
CERTIFIED CHIROPRACTIC ASSISTANT

Lisa Crawford
PATIENT ADVOCATE
CERTIFIED CHIROPRACTIC ASSISTANT

Dear Patient:

This office participates with most Insurance Companies, HMO's and PPO's. In most cases, we will agree to accept an assignment with Insurance Companies that we do not participate with.

It is your responsibility to follow up with you Insurance Company that you have Chiropractic Care Coverage. If you need a referral from your Primary Care Physician and you have not brought one with you, and you still choose to be seen, you are responsible for all charges in full.

Our office will call your insurance company to verify your coverage. We can only advise you of your coverage, based upon what the insurance company has told us over the phone. When this office receives the first Explanation of Benefits (EOB) and any corrections need to be made, we will do so at that time. You must understand that we follow your coverage based on what we are told at the time we call for benefits.

All co-payments and co-insurance payments are due on each visit or you may prepay weekly/monthly.

It is your responsibility to respond to any issues that your insurance company may request from you; i.e., additional information from the insured; forms that they may send you to complete and return. You need to look at any paperwork that you receive from YOUR INSURANCE COMPANY.

WE HAVE A 24 HOUR CANCELLATION POLICY. IF YOU DO NOT CALL TO CANCEL YOUR APPOINTMENT WILL BE BILLED FOR A "NO-SHOW APPOINTMENT!"

By signing below, you understand all of the above.

Signature _____ Date _____

23214 Brewers Tavern Way
Clarksburg, MD 20871
p: 240.745.2151
f: 240.745.2154

19392A Montgomery Village Ave.
Montgomery Village, MD 20886
p: 301.926.5200
f: 301.869.5417

10154 River Road, Suite 100
Potomac, MD 20854
p: 240.403.1703
f: 240.403.7126

3280 Urbana Pike, Suite 206
Urbana, MD 21754
p: 301.874.9002
f: 301.874.8511

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We have obtained your benefits for chiropractic coverage and the insurance company issued a disclosure that it is not a guarantee of payment. Benefits are subject to all contract limits and the member's status on the date of service. Accumulated amounts such as deductibles may change as additional claims are processed.

Reviewing your explanations of benefits from your Health Insurance Carrier will alert you to any outstanding balances you may be responsible for.

Patient Signature and Printed Name

_____

Date: _____

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PATIENT BILLING ACKNOWLEDGEMENT AND WAIVER OF NON-COVERED SERVICES

Under your health plan, you are financially responsible for co-payments, co-insurance or deductibles for covered services. You are also financially responsible for all non-covered services, including care determined to be elective or maintenance. You are also responsible for any charges not covered by your insurance company.

Maintenance/Elective care is treatment that does not significantly improve a clinical condition. While being treated for a chronic condition, you may elect to receive care beyond that which is determined to be medically necessary. You may also choose to receive maintenance care once maximum benefit from treatment has been reached.

If during the course of Maintenance/Elective care, you develop a new condition or a previous condition becomes significantly worse, it is your responsibility to advise the doctors and administration so that a request for insurance coverage can be submitted.

I _____, acknowledge that I have been told in advance by my provider that if services are not covered by my health insurance plan, that I am financially responsible for the charges.

Patient/Guardian Signature: _____

Date: _____ Printed Name: _____

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