



Confidential Patient Information

3641 Reavis Barracks Rd.

St. Louis, Missouri 63125

Phone: 636.219.9664

Web: www.performancestl.com

Date: ____/____/____

Patient's Full Name _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Date of Birth: ____/____/____ Male Female Spouse's Name: _____

Married Single Widowed Separated Divorced Number of Children/Ages _____

Social Security # _____ - _____ - _____ Referred by (Friend, Relative, Physician or Newspaper): _____

Status: Employed Full Time Student Part Time Student Retired Unemployed Occupation: _____

Employer: _____ Employer Address: _____ Business Phone _____

Primary Insurance Company _____ ID# _____ Group# _____

Insured's Name _____ Date of Birth: ____/____/____ Employer: _____ Relation to Insured: _____

Secondary Insurance Company _____ ID# _____ Group# _____

Insured's Name _____ Date of Birth: ____/____/____ Employer: _____ Relation to Insured: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Family Physician: _____ City: _____ State: _____ Phone _____

Previous Chiropractic Care: Yes No If Yes, for what Problem: _____

Doctor's Name: _____ City: _____ State: _____

What type of care are you interested in: Pain relief only Healing of current condition Optimizing your health All three

What is your long-term goal from treatment (e.g. play a round of golf without pain)? _____

Your education level: High school Some college College Graduate Post Graduate Other: _____

Is Today's Visit Due To A Work Related Injury: Yes No Is Today's Visit Due To An Auto Accident: Yes No
(If yes to either questions above, please check with receptionist, additional information is needed)

Date Of Injury: _____

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me.
2. I authorize my attorney and/or any insurance company to make **direct payment to you** of settlement proceeds.
3. I hereby assign and transfer to you the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your service. I authorize you to prosecute said action either in my name. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance companies, whether it be all or part of what was due, **I personally owe to you.**
4. I further agree that this Authorization and Assignment is irrevocable until all moneys owed to you (Performance Health Care LLC) are **paid in full.**

Patient Signature _____ Date ____/____/____



3641 Reavis Barracks Rd.

St. Louis, Missouri 63125

Phone: 636.219.9664

Web: www.performancehc.net

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

In general, would you say your health is (check one): [] Excellent [] Very good [] Good [] Fair [] Poor

PAST HEALTH HISTORY:

- 1. Have you ever experienced your present problem before for which you are consulting us: [] Yes [] No If yes, When: _____
Was treatment provided: [] Yes [] No If yes, By whom: _____ Outcome: _____
2. Have you ever had a stroke or issues with blood clotting? [] Yes [] No If yes, when: _____
3. Have you recently experienced dizziness, unexplained fatigue, weight loss, or blood loss? [] Yes [] No If yes, explain: _____
4. Have you ever had any major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries? [] Yes [] No

Table with 4 columns: Date, Injury/Fracture/Illness/Surgeries, Treatment, Results

SYSTEMS REVIEW QUESTIONS:

Do you or have you ever had any problems with the following areas? (Please mark Y for yes or N for no in each of the following:)

- 1. ___ Eyes 7. ___ Muscles 13. ___ Allergies
2. ___ Ears, Nose, Mouth, Throat 8. ___ Nerves 14. ___ Psychological/Emotional
3. ___ Heart 9. ___ Joints/Bones Females only:
4. ___ Lungs/ Breathing 10. ___ Skin 15. ___ Gynecological/Menstrual/Breast
5. ___ Intestines/Bowels 11. ___ Internal Organs Males Only:
6. ___ Urinary 12. ___ Blood 16. ___ Prostate/Testicular/Penile

Please explain any above Yes answers: _____

SOCIAL HISTORY:

Recreational Activities (Hobbies): _____

- Yes No
[] [] Do you exercise? _____ times per week
[] [] Do you smoke? _____ packs per day
If you have quit smoking, when did you quit? _____
[] [] Do you use other forms of tobacco? What/How much per day? _____
[] [] Do you consume alcohol? How many drinks per week? _____
[] [] Do you eat a balanced, low fat diet? If no, explain: _____
[] [] Do you take vitamins/herbs/supplements? If yes, explain: _____
[] [] Do you get adequate sleep? If no, explain: _____
[] [] Is work stressful to you? If yes, explain: _____
[] [] Is family life stressful to you? If yes, explain: _____
[] [] Do you use recreational drugs? If yes, explain: _____

Chief complaint: _____

Secondary or related complaint(s) if any: _____

Date of Onset/ When did your symptoms begin?: _____ Have you had this problem before? Yes No

Was the Onset: Gradual Sudden Since onset, has condition: Worsened Improved Remained the same

Describe what caused the pain: _____

Have you detected any possible relationship of your current complaint with any of the following:

Muscle Weakness Bowel/Bladder problems Digestion Cardiac/Respiratory Other: _____

Have you tried any self-treatment or taken any medication (over the counter or prescription): Yes No

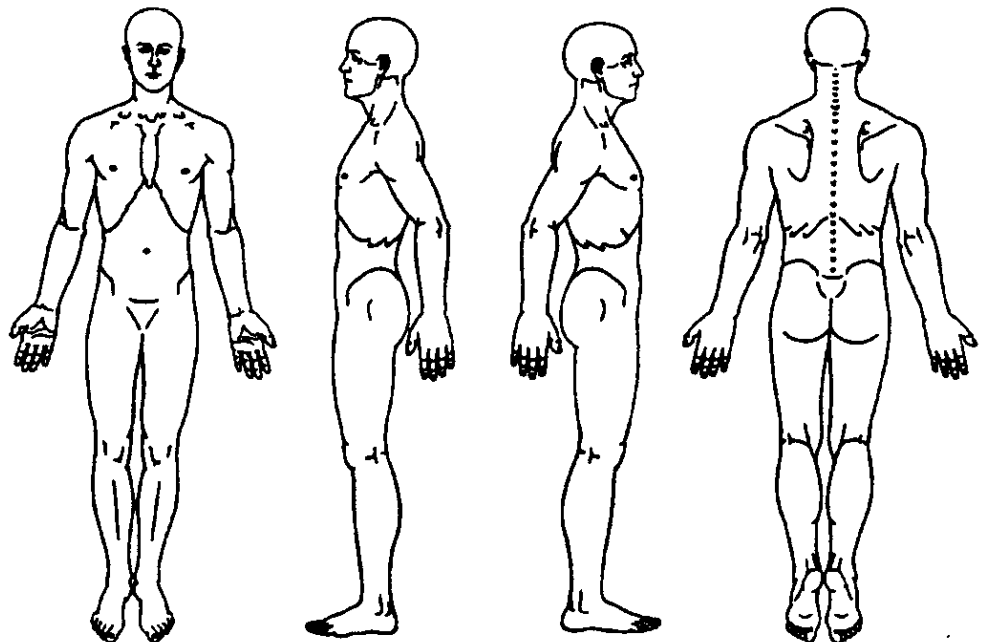
If yes, explain: _____ Results: _____

What medications are you currently taking? _____

Are you currently pregnant? Yes No Are you currently taking anti-coagulant or blood thinning medication? Yes No

PAIN CHART
Please mark areas of pain using these codes!

+++ Burning
Dull/Ache
*** Numbness/ Tingling
=== Throbbing
000 Stabbing/Sharp



(Front)

(Left)

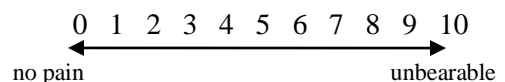
(Right)

(Back)

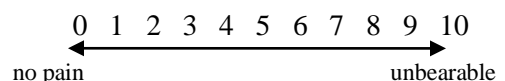
SEVERITY OF PAIN

List region of pain and circle the number which represents the intensity of your pain.

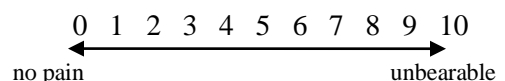
1. Complaint: _____



2. Complaint: _____



3. Complaint: _____





3641 Reavis Barracks Rd.

St. Louis, Missouri 63125

Phone: 636.219.9664

Web: www.performancehc.net

Insurance Verification

- ✦ **Insurance verification is not a guarantee of payment.** Verification is only a quote of patient benefits. Insurance companies review charges individually and make payment accordingly. **Charges not covered by insurance are the patient's responsibility and due within 30 days of billing.**

Deductible Payments

- ✦ **It is our policy to collect at time of service.** Once we receive an "Explanation of Benefits" report from the patient's insurance company, we will bill or credit the account for the remaining balance. Reimbursement checks can be issued upon request.

Collection of Patient Balance

- ✦ Co-payments and Co-insurance is the patient's responsibility and will be **collected at the time of service.**
- ✦ If an "Explanation of Benefits" or EOB shows the patient has an outstanding responsibility for any reason, the patient will receive a bill outlining the outstanding charges. **Payment is due within 30 days** of receipt of the bill.
- ✦ **In the event a bill is disputed, you must notify us within 30 days.** If you do not notify us within that time, the bill will be presumed valid and due. All balances remaining unpaid after 30 days will accrue **interest at the rate of 18% per annum.** In the event any further action is necessary to collect an unpaid bill, you will be responsible for all attorney's fees and court costs incurred by us.
- ✦ All balances remaining **unpaid after 30 days may be reported to a credit bureau** and affect your credit rating.

Returned Checks

- ✦ It is our policy to collect **\$25.00 for checks returned to us.** This is to cover any fees that apply from the transaction.

Appointments

- ✦ If unable to keep an appointment, as a courtesy to our staff and other patients, please give 24-hour notice. If it is a continual problem there will be a **\$20 charge** added towards your account each visit that is missed. The patient will be responsible for payment.

Financial Policy Questions

- ✦ We are happy to address questions regarding your account at any time. Please direct accounting questions to our billing administrator, Melissa Leonard.

HIPAA Privacy Policy

- ✦ Attached to the patient information packet at the back of these forms is the HIPAA Notice of Privacy Practices Policy for you.
- ✦ By signing below, the patient acknowledges that he/she has received the HIPAA Privacy Policy and that he/she understands and will comply with our financial policies.

Patient Signature

Date