# FINANCIAL AND MANAGED CARE POLICY STATEMENT

*NEO Spine & Sport adheres to the policies below. The patient/responsible party assumes the responsibility to ensure that the financial obligation is fulfilled for the health care received. We ask that you read and sign this Policy Statement prior to seeing your doctor.*

1. NEO Spine & Sport does NOT submit claims to out-of-network insurance companies, however, we can give you a super-bill to send in for reimbursement.
2. Patients with in-network insurance are expected to pay co-pays and deductibles at the time of service. Any personal balance is due immediately after the insurance company remits payment. If you receive an insurance payment at home on an outstanding bill at our office, the payment is to be forwarded to us immediately.
3. Not all services are covered benefits of all insurance plans. The patient/responsible party maintains the responsibility of verification of applicable coverage.
4. The patient is responsible for payment of any unpaid deductibles, co-insurance, or other known non-covered services at the time the service is provided. Uninsured patients are expected to pay in full at time of service.
5. Patients are requested to provide staff with sufficient notice to complete any forms, pre-certifications, or other forms required by your insurance company to process payments for services.

## Cancellation Notice

**Due to the doctor's high demand and limited available appointments, a $40.00 charge will be billed to your account for missed appointments without a 2 hour notice. A one-time exemption will be allowed.**

**Signature**_____**Date**_____

1. I have read and understand the Financial Policy stated above and agree to accept full responsibility as described above.
2. I agree that this authorization is valid regardless of when I receive services at this office and that I am the patient or authorized to sign this document.

_____ _____

Patient/Responsible Party Signature Date

***We accept cash, personal checks, and credit cards. (Visa, Mastercard, Discover)***

***Returned checks and balances older than 45 days may be subjected to additional collection fees.***

## Demographic Information

* Denotes required information

### Patient Name

Title: _____
Nick Name: _____
*First Name: _____
Middle Name: _____
*Last Name: _____
Suffix: _____

### Address

Address 1: _____
Address 2: _____
City: _____
State: _____
*Zip: _____

### Contact Information

Primary phone: _____
Secondary phone: _____
Mobile phone: _____
Work email: _____
Home email: _____
Best Contact Method: _____

### Personal Information

*Date of Birth: _____
Social Security Number: _____
*Gender: _____
Marital Status __ Single __ Married __ Other
Employment Status: __ Employed __ FT Student __ PT Student __ Retired __ Other __ Self Employed
Race: __ White __ Black/African American __ Hispanic __ American Indian/Alaska Native
__ Asian Indian __ Chinese __ Filipino __ Japanese __ Korean __ Vietnamese
__ Native Hawaiian/Pacific Islander __ Guamanian or Chamorro __ Samoan __ Other
Multi-Racial: __ Yes __ No
Ethnicity: __ Hispanic or Latino __ Non-Hispanic or Latino
Preferred language: _____

Verification Question:
__ In what city were you born?
__ What high school did you attend?
__ What is your favorite color?
__ What is your favorite movie?
__ What is the name of your favorite pet?
__ What street did you grow up on?
__ What was the make of your first car?
__ When is your anniversary?

Verification Answer: _____
Name of primary care physician: _____
Have you ever consulted a chiropractor before? __ Yes __ No
If so, who: _____
Last visit: _____
Referred by: _____

## Problem Areas

* Denotes required information

*Describe your problem: _____

*On a scale of 0-10 , rate the intensity: Lowest - 0 1 2 3 4 5 6 7 8 9 10 - Highest

*How did your problem begin: _____

*Onset date of problem: _____

How often do you experience symptoms: _____

What is the nature of your symptoms: __ Dull __ Sharp __ Throbbing __ Burning __ Deep
__ Aching __ Tingling __ Stabbing __ Cramping
__ Numbness __ Radiating

Does it affect other areas of your body: __ Yes __ No

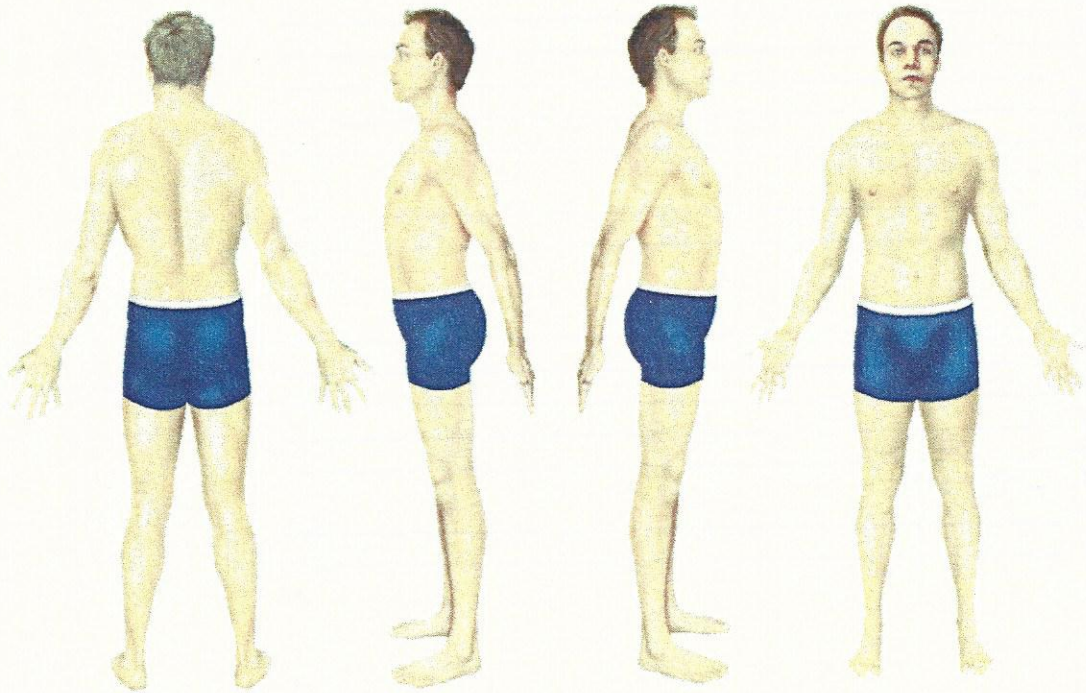
To what areas does the pain radiate, shoot or travel: _____

What makes it better or worse? (Times of day, movements, activities):

What have you done to relieve the symptoms: __ Prescription Medication __ Over the counter drugs
__ Homeopathic remedies __ Physical Therapy
__ Surgery __ Acupuncture __ Chiropractic
__ Massage __ Ice __ Heat __ Other

*What should we know about your current condition: _____

## Location of symptoms



## Allergies

* Denotes required information

*Name: _____
Medication related: __ Yes __ No
Symptom: _____
*Start Date: _____
Comments: _____

*Name: _____
Medication related: __ Yes __ No
Symptom: _____
*Start Date: _____
Comments: _____

## Personal Medical History

### Illnesses

Illness: _____
Start date: _____
End date: _____

Illness: _____
Start date: _____
End date: _____

### Surgeries

Surgery: _____
Date: _____

Surgery: _____
Date: _____

### Hospitalizations

Reason: _____
Date: _____
Duration: _____

Reason: _____
Date: _____
Duration: _____

### Injuries

Injury: _____
Date: _____

Injury: _____
Date: _____

## Family Medical History

### Illnesses

Illness: _____
Relation: _____
Age of onset: _____

Illness: _____
Relation: _____
Age of onset: _____

Illness: _____
Relation: _____
Age of onset: _____

Illness: _____
Relation: _____
Age of onset: _____

## Smoking History

* Denotes required information

*Do you currently smoke: __ Yes __ No

Years smoked: _____

Packs a day: _____

Interest in quitting on a scale of 0-10: Lowest - 0 1 2 3 4 5 6 7 8 9 10 - Highest

How long since you stopped: _____

## Social History

* Denotes required information

### Consumption

How much alcohol do you drink daily: _____

How many cups of coffee do you drink daily: _____

How much soda pop do you drink daily: _____

How much water do you drink daily: _____

How much do you depend on pain relievers: _____

Do you use recreational drugs: __ Yes __ No

### Stress Information

*How much physical stress are you under: Not much - 0 1 2 3 4 5 6 7 8 9 10 - A lot

*How much emotional stress are you under: Not much - 0 1 2 3 4 5 6 7 8 9 10 - A lot

What are the major stressors in your life: _____

### Sleeping Information

How many hours do you sleep per night: _____

What is your preferred sleeping position: _____

What type of mattress & pillow do you have: _____

How old are your mattress & pillow: _____

### Healthy Eating & Exercise Information

How much regular exercise do you perform: _____

*Rate your healthy eating habits: Not healthy - 0 1 2 3 4 5 6 7 8 9 10 - Healthy

Typical eating habits: __ Skip Breakfast __ 2 meals per day __ 3 meals per day
__ Snacking between meals

What would be the most significant thing that would improve your health:

_____

_____

What additional health goals do you have:

_____

_____

## Acknowledgements

| | | |
|---|---|---|
| **Chiropractic care:** | ☐ | I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity. |
| **Privacy Verification:** | ☐ | I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties. grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office. |
| **Permission to contact:** | ☐ | I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office. |
| **Payment Verification:** | ☐ | I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive. |
| **X-ray Verification:** *(females only)* | ☐ | I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant or I understand the risks.<br><br>Date of last menstrual period: |
| **General Verification:** | ☐ | To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern. |

Signature: _____ Date: _____