Swan Lake Chiropractic

724 Pearl Street, Boulder, CO 80302 | 303.449.3103 | swanlakechiro.com

Confidential Patient Case History

Name: _____ (*Preferred Name*): _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Date of Birth: _____ Sex: □ Male □ Female | Sex at Birth: □ Male □ Female | Gender: _____

Cell: _____ Home Phone: _____ Work Phone: _____

How did you find us/Who referred you?: _____

Emergency Contact's Name & Phone: _____

Occupation: _____

The information you provide will help us determine the stressors which have affected your spine, nervous system, & overall health

Birth & Early Childhood (0-5 years)

Please list any traumas, injuries, surgeries, or significant illnesses you are aware of:_____

_____

School Age Years (6-18 years)

Please list any traumas, injuries, surgeries, or significant illnesses you are aware of:_____

_____

_____

Activities you participated in:_____

_____

_____

Adult Years (19 +)

Please list any traumas, injuries, surgeries, or recurring health issues:_____

_____

_____

Current medications, dosage, and frequency:_____

_____

Have you been to a chiropractor before? □ Yes □ No Last adjustment: _____

Reason for Today's Visit:

Please describe your symptoms: _____

_____

Pain level today on a scale of 1-10: _____

Average pain level since this started on a scale of 1-10: _____

When did this start?_____

Have you had this or a similar condition in the past? _____

How does this affect your life?_____

What are your goals in seeking care for this condition? _____

_____

How committed are you to your health? (please circle one): Very Somewhat Not very much

Please rate your overall stress on a scale of 1-10: _____

How many times a week do you spend at least 20 minutes exercising?_____

How many times per week do you sit for greater than 30 minutes?_____

Appointment Policy:

Our time together is important. Please do your best to arrive on time for all of your appointments. As we get to know your body and treatment priorities, your appointment time will decrease. If you arrive ***more than 5 minutes*** late to our scheduled time together, we may have to reschedule your appointment for another time or day.

Please initial that you have read and understand the appointment policy: _____

Consent to Treatment:

I give permission for Swan Lake Chiropractic to evaluate me and to give me medical treatment.
I understand that:

- Swan Lake Chiropractic will have to send my medical record information to my insurance company if I am electing to bill my insurance.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

I understand:

- That options exist for treatment; and, all treatments are choices between risks and benefits.
- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician.

Patient's Signature: _____ Date: _____

Responsible Party's Signature, if patient is a minor: _____ Date: _____

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Please read our PAYMENT GUIDELINES and select one of the following options:

_____ Self Pay Plan – I, the patient, understand that I am responsible for all charges accrued from office visits. Payment is required when services are rendered. No third party is involved. A receipt or superbill can be generated for me to pursue my own reimbursement.

_____ Medical Insurance Plan – I hereby authorize the assignment of benefits to Swan Lake Chiropractic as well as the release of any medical information necessary for the payment of claims. I, the patient, am responsible for any co-pays or deductibles due at the time the services are rendered. If after 90 days Swan Lake Chiropractic is unsuccessful recovering monies from my insurance carrier, I understand that I am ultimately responsible for charges accrued from office visits, etc.

I have read and understand the payment policy of Swan Lake Chiropractic Health Centre as explained in the PAYMENT GUIDELINES. I also acknowledge that all charges incurred in this office are ultimately my responsibility.

Name: _____ Date: _____

Signature: _____

Please read our NO-SHOW/LATE CANCELLATION policy:

If a patient fails to appear at the time of their appointment and has not contacted our office with at least 3 hours' notice, they will be considered a No Show. Because we understand life happens and obstacles come up that are beyond your control, we will not charge any fee for the first No Show. We will, however, contact you for a credit card number to keep on file so we have means of collecting a fee if it happens a second time.

Any patient who fails to appear at their appointment, who cancels/reschedules within a 3-hour period for a second time, or who is more than 5 minutes late for their appointment will be charged our full adjustment rate of $60. This same charge will be applied for any subsequent No Shows. The fee will be charged immediately on the card on file.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. In such instances, please contact us before the appointment and we will waive the No Show fee when appropriate.

Signature: _____

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____ have been notified of my option to receive a copy of this office's Notice of Privacy Practices and that this practice abides by those policies.

_____ (Signature)

_____ (Date)

_____ FOR OFFICE USE ONLY _____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtainment
- An emergency situation prevented us from obtainment
- Other (please specify):

_____

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Welcome Medicare Patient

As you are a recipient of Medicare benefits, it is our desire to clarify to you how these benefits presently relate to chiropractic.

We are Medicare Providers with non-participating status.

AFTER a $233 deductible (as of 1/1/2022) has been satisfied, Medicare will only pay for manual manipulation of the spine, related to active treatment, and will pay for 80% of the allowable amount for visits deemed eligible, up to 30 visits per calendar year.

As non-participating providers, you will pay us directly at the time of the visit. As a courtesy to you, we will bill Medicare for all your visits. If you have a secondary insurance, Medicare will forward the claim to them and they will process the claim according to the benefits of that supplemental policy. Once processed, Medicare and your secondary will each issue you a check of any amount due to you.

Please understand that Medicare does not guarantee payment on submitted claims. Please understand also that we have no control over these laws. Let us know if we can help further clarify or explain anything relating to your Medicare benefits or your care here at Swan Lake Chiropractic.

What you can expect as a Medicare patient:

Please initial each line.

____ Please alert us every time you have a new condition or your condition has changed.

____ Medicare does NOT pay for Maintenance Care. It pays for spinal manipulation, as long as you're under active treatment for a current condition(s).

____ Maintenance Care visits will be processed at a rate of $45.00 for which you are responsible.

____ Medicare does NOT cover: Decompression Therapy ($65), Initial new-patient examinations ($82), Re-examinations ($15-$35), Extra-spinal (extremity) Adjustments ($10).

_____

Patient's Signature

_____

Date