BERND
CHIROPRACTIC

CONFIDENTIAL PATIENT QUESTIONNAIRE

PERSONAL INFORMATION	Name: _____ Middle Initial: _____ Today's Date: ____/_____/_____ Email: _____ Home Phone: _____ Cell Phone: _____ Work Phone: _____ Preferred number: __Home __Cell __Work Address:_____ City: _____ State: _____ Zip: _____ DOB: ____/_____/_____ SSN: _____ Marital Status: __M __S __D Occupation: _____ Employer Name: _____ Emergency Contact Name: _____ Relationship to you: _____ Contact Phone: _____ How did you hear about us? ___ Online ___ Word of Mouth ___ Doctor Referral If you were referred to us, please let us know who referred you: _____ Patient Signature: _____
FINANCIAL & INSURANCE INFORMATION	Name of Party Responsible for Payment: _____ Social Security # (if different from above):_____ Do you have Insurance: __Y __N Insurance Company:_____ _____ Policy # Group Plan # Medicare # (if applicable)
CURRENT COMPLAINT	Describe Your Current Complaint(s) (Reason for Visit): _____ _____ _____
PRE-EXISTING CONDITIONS	Have you sought care for a health condition in the past year: ____Y ____ N Past 2 Years: __Y __ N If yes, what condition: _____ Was treatment administered: ___Y ___ N Describe: _____ Do you take Medication: ___ Y ___ N Describe: _____

OTHER MEDICAL CARE

At the onset of any current complaints, were you under any medically prescribed disabilities or self- imposed restrictions: ___Y ___ N If yes, please describe:

_____

List any other doctors seen for this condition

_____

Doctor Name *Address*

_____

Doctor Name *Address*

Did you go to the hospital: ___Y ___ N

If yes, how did you get to the hospital: ___ Ambulance / Other: _____

If admitted, how long did you stay: _____

What type of treatment did you receive? (Include X-rays, recommendations, etc.)

_____

Medication prescribed: __Y __N List name(s) of medication: _____

_____

GENERAL HEALTH HISTORY

__ Cancer __ Epilepsy __ Digestive Problems __ Asthma __ Neuritis
__ Tuberculosis __ Dizziness __ Rheumatism __ Hepatitis __ Migraine
__ Hypertension __ Convulsions __ Venereal Disease __ Anemia __ Heart Attack
__ Numbness __ Diabetes __ Concussion __ Polio
__ Multiple Sclerosis
__ Arthritis __ Allergies __ Back Problems __ Tingling __ Sinus History
__ Muscular Dystrophy __ Rheumatic/ Scarlet Fever

If Female, are you pregnant: __ Y __ N __ Not Certain

Any prior hospitalizations or surgeries? (Please List): _____

_____

PRESENT COMPLAINTS

__ Headache __ Neck Pain/Stiff __ Chest Pain __ Concentration Loss
__ Shortness of Breath __ Diarrhea __ Numbness __ Memory Loss
__ Digestive Trouble __ Vomiting __ Upper Back Pain __ Swelling
__ Anxiety __ Mid Back Pain __ Cold Hands __ Low Back Pain
__ Depression __ Cold Feet __Ringing in Ears __ Shoulder Pain
__ Insomnia __Loss of Balance __ Arm Pain __ Fatigue
__ Loss of Smell/Taste __ Flushed Face __ Bleeding __ Leg Pain
__ Pale Face __ Broken Bones __ Pain Behind Eyes __ Bruises
__ Sinus Trouble __ Alcohol Intolerance __ Vision Problems __ Neuritis
__ Fainting __ Excess Perspiration __ Constipation __ Nausea
__ Cuts __ Dizziness __ Loss of Consciousness __ Irritable
__ Jaw Pain __ Eyes Sensitive to Light __ Neck Motion Restricted __ Nervousness
__ Pins and Needles Arms/Legs __ Head Feels Heavy __ Heart Palpitations

Radiation of Pain into: __ Rt. Arm __ Left Arm __ Both __ Right Leg __ Left Leg __ Both

Pain Aggravated Upon: __ Walking __ Sitting __ Standing __ Bending __ Riding __ Lying Down

Other Complaints? (Please List): _____

Bernd Chiropractic Financial Policy

Welcome to Bernd Chiropractic. We would like our patients to understand our fees and be satisfied that they are reasonable and equitable. Please note that payment is **ALWAYS** due at the time of service. We accept MasterCard and Visa and if necessary, we can take a postdated check. If for some reason you cannot make payment at the time of your appointment, please discuss the matter with our receptionist (BEFORE BEING SEEN) so that a mutually satisfactory agreement can be arranged.

General Insurance:

Please note that Bernd Chiropractic is **not** affiliated with any Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO). We wish to stress that the financial responsibility for services rendered rests with the patient (or responsible party), regardless of insurance coverage. As a courtesy, we will bill your insurance company for you, but do **not** take responsibility for knowing any patient's eligibility, coverage, or benefits. Any amount left unpaid by insurance is the sole responsibility of the patient.

Medicare Part B:

Medicare patients are also responsible for payment at the time of service. As a courtesy, we will bill Medicare for you, and you will be reimbursed by Medicare directly. Medicare will typically pay for 12 adjustments per year and cover 80% of the Medicare approved amount after your annual deductible is met. Below is a breakdown of our Medicare charges:

Service	Reimbursement from Medicare	Amount We Charge
Spinal Manipulation (chiropractic adjustment to the neck, upper back and/or lower back)	Medicare will typically reimburse patient 80% of this charge	$41.63
Extraspinal Adjustments (anything other than the spine; i.e., rib, hip, etc.)	NOT covered by Medicare	$5.37

Other services **NOT** covered by Medicare include chiropractic X-rays, supplements, therapy modalities and supports. You are expected to pay for these services when rendered or purchased.

Medicare Advantage:

If you have enrolled in a Medicare Advantage plan ("MA" plan or Part C) in which another insurance company administers your Medicare benefits, this means Medicare no longer pays for your healthcare. If this is the case, we need to know this so that we do NOT bill Medicare on your behalf. As a reminder, Bernd Chiropractic is NOT a member of any Health Maintenance or Preferred Provider Organization, meaning you do NOT have the benefit of the Medicare coverage mentioned above, and would be directly responsible for any services rendered. If you have turned your Medicare benefits over to a Medicare Advantage plan, please indicate which organization below:

☐ Blue Cross ☐ Blue Shield ☐ Kaiser Permanente ☐ Other: _____

Missed Appointments:

We require 24 hours' notice when cancelling or rescheduling an appointment. A $25 fee may be assessed if appointments are missed (or rescheduled) without the proper notice.

PATIENT SIGNATURE DATE

_____ _____

ONLY COMPLETE THIS SECTION IF YOUR VISIT IS DUE TO AN ACCIDENT

ACCIDENT HISTORY	Type of Accident: __Auto __ Workers Comp __ Fall __ Other Date of Accident: _____ Brief Description of Accident:_____ _____ _____
AUTO ACCIDENT HISTORY	Were seat belts worn: ___ Y ___ N ___ Shoulder ___ Lap Seat position in vehicle: _____ If Vehicle had headrests, describe position compared to your head: ____ Top of headrest aligned with top of head ____ Top of headrest aligned with middle of head ____ Top of headrest aligned with bottom of head Briefly describe the collision impact: ___ Head on collision ___ Left side impact ___ Right side impact ___ Rear end collision List any parts of your body that contacted vehicle parts: _____ Were you braced for impact: __Y __ N Were brakes applied: __Y __ N Were you looking up into rearview mirror: __Y __ N Were you looking at outside door mirror: __Y __ N Was your vehicle stopped: __Y __ N Any previous motor vehicle accidents: __Y __ N If yes, describe:_____ _____

Personal Injury Insurance Verification

Patient's Name: _____

Insured's Name (if not patient): _____

Name of Insurance Company: _____

Billing Address: _____

_____

Phone #: _____

Agent's Name: _____ Phone #: _____

Adjuster's Name: _____ Phone #: _____

Policy #: _____ Claim #: _____

Do you have med-pay coverage: __Y __N If so, how much?: _____

How much has been used: _____ Date of accident: _____

Have you filed a claim with your Insurance Company: __Y __N

Information of Other Party:

Name: _____

Insurance Company: _____

Billing address: _____

_____

Agent's Name: _____ Phone #: _____

Policy #: _____ Claim #: _____

Will bills be paid on an ongoing basis or upon settlement? _____

What is the liability limit: _____

Do you have a Private Health Insurance Carrier:_____

Billing address: _____

_____

Attorney's Name: _____ Phone #: _____

Billing address: _____

_____