**Popple Family Chiropractic, PC**

**CONFIDENTIAL PATIENT HEALTH HISTORY**

Please PRINT clearly.

**Today’s Date**:

PATIENT INFORMATION

**Name**: (Last, First, MI) **Preferred Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Address**: **City**: **State**: **Zip**: \_\_\_\_\_\_\_\_\_\_

**Home Phone**: **Mobile**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social Security number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender**: M / F **Marital Status**: Married / Single / Other

**Email**: **Date of Birth:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Employer:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Spouse/Significant Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Children and Ages:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you:** Military Veteran / Active Duty Service Member / Reservist / National Guard / ROTC

**Referred by** *(name)***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***-CMS requires providers to report both race and ethnicity-***

**Ethnicity**: Not Hispanic or Latino / Hispanic or Latino / Other / Decline to Answer **Preferred Language**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Race**: Asian / Black or African American / American Indian or Alaskan Native / White (Caucasian) / Hawaiian or Pacific Islander / Other / Decline

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT INFORMATION

**Full Name**: **Preferred Contact Number**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship**: Child / Parent / Spouse / Other:

**Primary Care Physician**: **Doctor’s Phone**:

FINANCIAL INFORMATION -- ***Please allow us to photocopy your insurance card.***

**Self Pay (Cash) Insurance Personal Injury/Auto Other (please explain)**

**PRIMARY INSURANCE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SECONDARY INSURANCE**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Holder & DOB**: \_\_\_\_\_\_\_\_\_\_\_\_ **Policy Holder**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relation to Insured**: Self / Spouse / Parent / Child / Other **Relation to Insured**: Self / Spouse / Parent / Child / Other

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**Patient Name**:

CURRENT CONDITION INFORMATION *PLEASE ANSWER ALL QUESTIONS*

**Major Complaint**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When Did It Start (date):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **What Event Caused It:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

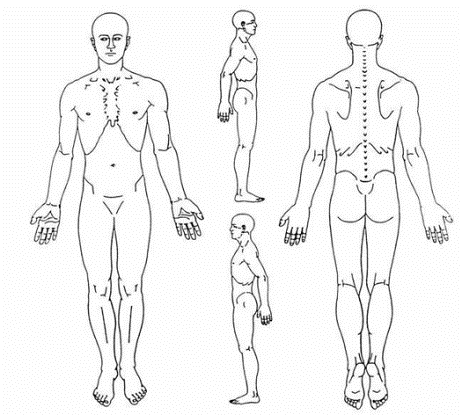
**Intensity:** None (0) Mild (1-2) Mild-Moderate (2-4) Moderate (4-6) Moderate-Severe (6-8) Severe (8-10)

**Is The Complaint:** Constant / Off and On

**Is The Complaint**: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Pins and Needles Other:\_\_\_\_\_\_\_\_\_\_\_\_

**Does It Radiate/Shoot To Any Areas Of Your Body?** No / Yes **If YES, where:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Draw Areas of Complaints:**



**What Makes It Better?** Ice / Heat / Rest / Movement / Stretching / OTC Meds / RX Meds / Chiropractic

**What Makes It Worse?** Sit / Stand / Walk / Lying / Sleep / Movement

**Who Else Have You Seen For This?** No One / DC / MD / PT / Massage / ER / Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**- Where:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_

**Diagnostic Tests:** None / X-rays / MRI / CT / Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **When and Where:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any Other Complaints**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you pregnant? If so, how many weeks?\_\_\_\_\_\_\_\_\_\_\_**

**Who is a part of your birth team (OBGyn/Midwife/Doula)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Smoking Status**: Every Day / Some Days / Former / Never **Alcohol Use:** Every Day / Weekly / Occasionally / Never

**Exercise Frequency:** Daily / 3-4x per week / 2-3x per week / Rarely / Never **Rate Stress:** None / Mild / Moderate / High

**What factors cause stress in your life? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Water Intake:** None / Moderate / High **Caffeine Intake:**  None / Moderate / High **Diet/Nutrition:** Mostly whole, healthy foods / Average / Poor

**How often do you eat during the day?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Do you follow a specific type of diet?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sleep Habits:** What time do you typically go to sleep? \_\_\_\_\_\_\_ What time do you typically wake up? \_\_\_\_\_\_ Do you sleep through the night? **Y/N**

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**Does anyone in your IMMEDIATE family have a history of (circle condition)**:  **NONE**

**Heart Disease** If yes, who \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Stroke** If yes, who \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cancer** If yes, who \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Other Relevant Family History**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST HEALTH HISTORY:** (List even if it was 20 years ago…)

**Injuries, Traumas or Hospitalizations: NONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Car Accidents, Falls, Sports:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Surgeries – Date, Type and Reason: NONE \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications: *Did you bring a list? Can we make a copy?*  NONE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies to Medications**: *(List and reactions)* **NONE** **Vitamins & Supplements:** *(List all and brand)*  **NONE**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you *currently* experiencing any of these symptoms? (Check all that apply)**

|  |  |  |
| --- | --- | --- |
| **General:** | **Cardiovascular & Heart:** | **Endocrine, Hematologic, and Lymphatic**: |
|  Recent Intentional Weight Change |  Chest Pains |  Thyroid Problems |
|  Fever |  Rapid or Heartbeat Changes |  Diabetes |
|  Fatigue |  Blood Pressure Problems |  Cold Extremities |
|  *None in this Category* |  Swelling of Hands, Ankles, or Feet |  Heat or Cold Intolerance |
| **Musculoskeleta**l: |  Heart Problems |  Immune System Disorder |
|  Low Back Pain |  *None in this Category* |  *None in this Category* |
|  Mid Back Pain | **Respiratory:** | **Skin and Breasts:** |
|  Neck Pain |  Difficulty Breathing |  Rash or Itching |
|  Arm Problems |  Persistent Cough |  Non-healing Sores |
|  Leg Problems |  Coughing Blood |  Breast Pain |
|  Broken Bones |  Asthma or Wheezing |  Breast Lump |
|  Muscle Spasms/Cramps |  Tobacco Use |  Breast Discharge |
|  *None in this Category* |  *None in this Category* |  *None in this Category* |
| **Neurological:** | **Eyes and Vision:** | **Genitourinary:** |
|  Numbness or Tingling Sensations |  Wear Contacts/Glasses |  Kidney Stones |
|  Loss of Feeling |  Blurred or Double Vision |  Burning/Painful Urination |
|  Dizziness or Light Headed |  Eye Disease or Injury |  Change in Force/Strain w/Urination |
|  Frequent or Recurrent Headaches |  *None in this Category* |  Frequent Urination |
|  Convulsions or Seizures | **Ears, Nose and Throat:** |  Urinary Leakage or Bed Wetting |
|  Have you ever had a head injury? |  Swollen Glands in Neck |  Blood in Urine |
|  Had an auto accident? Year:\_\_\_\_\_\_\_\_ |  Ringing in the Ears |  *None in this Category* |
|  *None in this Category* |  Ear-Ache/Ringing/Drainage | **Women Only:** |
| **Gastrointestinal:** |  Sinus/Allergy Problems | **Are you pregnant?** |
|  Loss of Appetite |  *None in this Category* |  Yes-Due Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Blood in Stool | **Mind/Stress:** |  No-Last Menstrual Period: \_\_\_\_\_\_\_\_\_\_\_\_ |
|  Change in Bowel Movements |  Nervousness |  Painful or Irregular Periods |
|  Nausea or Vomiting |  Depression |  Urine Leakage with Coughing or Sneezing |
|  Abdominal Pain |  Sleep Problems |  Urine Leakage with Laughing or Lifting |
|  Constipation |  Memory Loss or Confusion |  *None in this Category* |
|  *None in this Category* |  *None in this Category* | **Pregnancies with Outcome & Date** |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Is there anything else you would like us to know? | |  |

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state’s statutes. I choose to decline receipt of my clinical summary after every visit. (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient or Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Consent for Chiropractic Services***

**By reading below I have been made aware:**

1. The process of delivering a “Chiropractic Adjustment (manipulation)” may be performed manually, with a table mechanism to the vertebra(e) of the spine and/or associated structures (legs, arms etc.), often resulting in an audible pop or click sound;
2. As an addition to the Chiropractic Adjustment “Supportive Therapies and/or Procedures” may be applied by the chiropractor or by staff under the chiropractor’s direction or supervision incorporating the use of acupuncture, vibration, electricity, traction, motion, bracing, nutritional advice, heat, or cold;
3. That on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment;
4. That the chiropractor has made no guarantee of a positive outcome from treatment.

**Additionally:**

1. I have been afforded ample opportunity for questions and answers.

**Therefore by signing below:**

**I consent** to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

**I consent** to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If patient is a MINOR:**

I hereby authorize Dr. Ashton Popple to administer examinations and chiropractic care as deemed necessary to:

Minor Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Before this office begins any health care operations, we require you to read and sign this form stating that you understand the below item. If you refuse to sign this form the doctor reserves the right to refuse care.

***Insurance Benefits/HIPAA/Privacy Practices***

**AUTHORIZATION:** By signing below you authorized this office/provider to complete a consultation and examination on the above.

**AUTHORIZATION FOR X-RAY WITH RELEASE:** By signing below you have declared, to the best of your knowledge, that there is no chance you are pregnant at this time. By signing below you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below you consent to the taking of x-rays if there is a determined need.

**ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS:** By signing below you have acknowledged that you are fully responsible for all services rendered. By signing below you furthered acknowledge understanding that your health and accident insurance information policies are an arraignment between you and your carrier, and that you may be required to pay some or all of the fees charged to your account. By signing below you hereby assign benefits to paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.

**­CMS-1500 HEALTH INSURANCE CLAIM FORM**: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state “Signature on File”. Box 12 Reads as follows: “PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.” Box 13 Reads as follows: “INSURED’S OR AUTHORIZED PERSON’S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.”

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:** We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below you have authorized this office to contact you for office related matters in the following manner: phone-work-home or mobile, e-mail and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated May 24, 2018, this office is obliges to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of this document.

**ACKNOWLEDGEMENT OF TREATMENT PLAN:** By signing below I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.

**ACKNOWLEDGEMENT:** By signing below you have acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below you acknowledge and certify that all the information given to the office/provider in the INTAKE forms are a true and accurate to the best of you knowledge.

Patient Signature & Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Popple Family Chiropractic, PC | Financial Policy***

All our patients will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it pertains to your particular situation.

**CASH PAY** For uncovered services, payment is due at the time services are rendered, or at the beginning of your care unless other financial arrangements are made. Cash, personal checks, Visa and Mastercard are accepted. If a true hardship exists, we will be happy to assist you in making financial arrangements via written agreement (authorized by the doctor).

**TIME OF SERVICE DISOUNT FOR ACTIVE MILITARY/VETERANS/FAMILY MEMBERS** For uncovered services, payment is due at time services are rendered. Active military/veterans/and their immediate family members will receive a time of service discount of $15.00 on daily visits (total cost for daily visit $35.00) (after full price initial exam and x-rays).

**HEALTH INSURANCE** Popple Family Chiropractic, PC provides its services directly to you, not your insurance company. You are ultimately liable for your bill. We will verify your benefits & coverage, however the benefits represented to us by your insurance company are not a guarantee of payment. As a service to our patients, we will submit your bills to your insurance company. All co-pays/co-insurances are due at the time of service. You are responsible for your deductible if it has not already been satisfied, and payment plans are available. If you are filing your own claims, we will provide you with an itemized bill. \*\*\*\*IN THE EVENT THAT WE ARE BILLING YOUR INSURANCE COMPANY AND A CHECK IS MAILED TO YOU, YOU MUST FORWARD IT INTO OUR OFFICE WITHIN 7 DAYS SO THAT WE MAY PROPERLY CREDIT YOUR ACCOUNT.

**WORKERS COMPENSATION** If you were injured in the course of employment, your care should be paid for under your employer’s Workers’ Compensation insurance. Notify your employer in writing immediately of the accident. Ask for instructions. 1) Obtain the name, address, phone number and adjuster for your employer’s Workers Compensation insurance company, and notify them that you are treating at our office. 2) Notify our office of the injury and fill out the necessary paperwork for a workers compensation claim. 3) Make sure your employer has notified and sent a report to their workers compensation carrier. Completing these few steps will help ensure you get the care and benefits you are entitled.

**AUTOMOBILE ACCIDENT/PERSONAL INJURY** If you are injured in an automobile or other accident, you are eligible for benefits under your auto or other insurance policy. You should inform our office immediately if you were involved in an accident. The necessary paperwork must be filled out completely and to the best of your knowledge. You must furnish our office with your insurance company name, claim number, adjusters name and phone number within 5 days of your first date of service. At that time you can inform us of any legal representation you have obtained. We will furnish your attorney with the progress report and information regarding your health as it is needed.

I have read and understand the financial policy of POPPLE FAMILY CHIROPRACTIC, PC. In the event my insurance company does not pay the charges I have incurred at this office, I agree to pay any and all fees accumulated within 90 days of the date of service.

Patient’s Signature (Guardian if Patient is a Minor)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_