Patient Data Sheet

Date _____

First Name _____ ***MI*** _____ ***Last Name*** _____

Date of Birth: _____ ***Age:*** _____ ***Gender:*** _____

Mailing Address: _____

City: _____ ***State:*** _____ ***ZIP:*** _____

OK to Call	*Phone #*	*Best Time To Call*
☐	Home: _____	_____
☐	Work: _____	_____
☐	Cell: _____	_____
☐	Message: _____	_____

Email Address: _____

SSN#: _____

Race:

☐ Declined to Provide ☐ American Indian/Alaska Native ☐ Asian
☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White

Ethnicity: ☐ Declined to Provide ☐ Hispanic or Latino ☐ Not Hispanic of Latino

Preferred Language: _____
Interpreter required? ☐

Marital Status: _____
If married, spouse's name: _____

Patient Employer Information:
Employer: _____ ***Occupation:*** _____
Address: _____
Phone: _____

Spouse Employer Information:
Employer: _____ ***Occupation:*** _____
Address: _____
Phone: _____

Emergency Contact:
Name: _____
Address: _____
Phone #: _____
Relationship: _____

Insurance Information:

Do you have insurance? ☐ Yes ☐ No

Primary Insurance: _____

Policy Holder's Name: _____ ***Holder's Birthdate:*** _____

Policy or Certificate #: _____ ***Group #:*** _____

Policy Holder's Employer: _____

Secondary Insurance: _____

Policy Holder's Name: _____ ***Holder's Birthdate:*** _____

Policy or Certificate #: _____ ***Group #:*** _____

Policy Holder's Employer: _____

Will this case involve Workman's Comp? ☐ Yes ☐ No

Will this case involve legal action? ☐ Yes ☐ No

Date of accident, if any _____ ***Related to:*** ☐ Work ☐ Auto ☐ Other

Please Note: We cannot accept responsibility for collecting your insurance claim or for negotiating a settlement regarding a disputed claim. Payment for the office charge is expected at the time services are rendered.

Patient Signature: _____

For New Patients Only:

We would like to thank the person(s) who referred you to us. Please take some time to fill this out as completely as possible.

How did you learn about the Ortman Clinic? (Mark with an X)

_____ ***Another Patient*** – Name _____

Address _____

City _____ State _____ ZIP _____

Relationship _____ Birthdate _____

_____ ***Another Doctor*** – Name _____

Address _____

City _____ State _____ ZIP _____

_____ ***Newspaper advertisement*** – which paper _____

_____ ***Yellow Pages***

_____ ***Internet***

_____ ***Television*** – which station _____

_____ ***Other*** – please explain _____

If you know of anyone that we could help or would possibly like some information about the clinic please give us their name and address.

Name _____ Address _____

City _____ State _____ ZIP _____

ORTMAN CHIROPRACTIC CLINIC

FOR OFFICE USE ONLY
HANDOUT
Y N

PO Box 157
209 W Main St
Canistota, SD 57012
PH. 605-296-3431

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Family Medical History ***(Record one diagnosis in your family history and the affected relative)***				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease		*X*		

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

☐ **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 Signature: _____ Date: _____

Height: _____ Weight: _____ Blood Pressure: _____ / _____

ORTMAN
CHIROPRACTIC CLINIC

Thank you for choosing Ortman Chiropractic Clinic for your healthcare needs. We are committed to providing you with the best possible care. In an effort to ensure the billing process goes as smoothly as possible it is important that you understand our office policies. We are happy to discuss any questions you may have. Please keep a copy of our policies for your records.

Method of Payment

PLEASE CHECK THE APPROPRIATE BOX BELOW INDICATING YOUR METHOD OF PAYMENT.

- ☐ NON-INSURANCE (Cash/Private Pay)
- ☐ HEALTH INSURANCE
- ☐ ACCIDENT
- ☐ WORKERS COMPENSATION CLAIM
- ☐ Other: _____

Ortman Chiropractic Clinic's Promise to You

- Ortman Chiropractic Clinic offers a time-of-service discount for services not covered by insurance and paid on the day of service. The following types of payment are accepted: cash, check, MasterCard, Visa and Discover Card.
- Ortman Chiropractic Clinic will file insurance claims for anyone who presents an insurance card or other information needed to file a claim.
- In the event that a patient's insurance company pays more than what was originally quoted, Ortman Chiropractic Clinic will send the patient a refund check or apply the credit to the patient's account for future visits.
- Upon patient request, Ortman Chiropractic Clinic will verify insurance coverage. However, benefits quoted are not a guarantee of payment. Benefits are determined at time of claims processing.
- A copy of Ortman Chiropractic Clinic Patient Responsibility will be given to each patient.
- In addition to your treatment, other charges may apply. These include therapies, exams, supplements, orthotics, supports, etc.

Note: Any patient who fails to arrive for a scheduled appointment without notifying us is considered a "no-show". We will be charging a $75 charge per occurrence after the third incident.

I acknowledge that I understand and will abide by the Ortman Chiropractic Clinic Patient Responsibility policy. I am responsible for payment of all services rendered at each visit.

_____ _____

Signature of Responsible Party Date

Ortman Chiropractic Clinic Patient Responsibility

INSURANCE:

- If an insurance card or other information needed is not presented at the time-of-service, patient will be a Cash/Private Pay patient. Once the insurance card or other information is presented, Ortman Chiropractic Clinic will bill your insurance.
- Patients are responsible for any portion of the bill which is left unpaid by insurance.
- Non-covered services, deductibles, co-pays, and co-insurance must be paid at the time of service.
- Medicare will only pay for adjustments to the spine. Any other treatment received will be the patient's responsibility.

ACCIDENT:

- Patient is responsible for giving Ortman Chiropractic Clinic the **claim number, insurance carrier, adjuster's name & phone number, and date of injury** of your case and filling out all needed data in order to file your claim. There are forms on our website or available in our office that can assist you in getting this information.
- If your claim is denied, you will be responsible for payment in full.

WORKER's COMPENSATION CLAIMS:

- Patient is responsible for giving Ortman Chiropractic Clinic the **claim number, insurance carrier, adjuster's name & phone number, and date of injury** for your case and filling out all needed data in order to file your claim. There are forms on our website or available in our office that can assist you in getting this information.
- If the claim is denied, the patient will be responsible for payment in full.

Updating Personal Information

- It is the patient's responsibility to update their personal information file every time the personal information changes.

Additional Payment Information

- Payments must be made on a regular basis, at least one payment each money.
- Checks returned due to non-sufficient funds (NSF) will be assessed a $20.00 charge. After two NSFs, checks will no longer be accepted as a method of payment.
- Patients who have had delinquent accounts in the past may be required to pay for future visits "up front," in cash.
- If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency (90 days past due), you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs.

Ortman Chiropractic Clinic will work with patients in order for them to meet their financial responsibility for care and services.

ORTMAN
CHIROPRACTIC CLINIC

Notice of Receipt of Privacy Policy

and

Appointment Reminders, Phone Calls and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you are required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (~ 164.524).

From time to time family or friends call to contact you while you are at the clinic for emergencies, etc. By signing below you give us authorization to tell them you are a patient and whether you are here or not.

This notice is effective as of April 16, 2003. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization. And that I have received a copy of **Ortman Clinic Privacy Policy.**

X _____ X _____

Patient Name Printed — Date

X _____ _____

Patient Signature — Authorized Provider Representative

_____ _____

Personal Representative Printed — Personal Representative Signature

_____

Description of personal representative's authority to act for the patient.

☐ **Patient Refused to Sign**

Informed Consent To Chiropractic Treatment

Medical doctors, Chiropractic doctors, Osteopaths and Physical Therapists that perform manipulation are required by law to obtain your informed consent before starting treatment.

I do hereby give my consent to the performance of conservative non-invasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy, ultrasound, traction, laser, exercises and other therapeutic modalities may also be used.

Although spinal manipulation/ adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that, like exercise, it is common to experience some muscle soreness in the first few treatments. These are likely temporary symptoms.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects or weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, our office will proceed with extra caution.

Stroke/CVA: Although strokes do happen with some frequency in our world, strokes from a chiropractic treatment are very rare. We use a non-aggressive technique for treatment and take the utmost care to prevent any type of nerve damage to our patients.

Treatment Results

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I agree to the performance of these procedures by my doctor and such other person of the doctor's choosing.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

My Signature on this consent form is good until I inform the Ortman Clinic otherwise in writing.

_____ _____

Date **Patient Signature**

_____ _____

Date **Patient Guardian Signature (If patient is under 18 years of age.)**