**Hankison Family Chiropractic & Acupuncture, Inc.** **Acupuncture Intake Form**

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Spouse's Name _____ Number of Children _____

Person Responsible for Bill _____ Referred By _____

IN CASE OF EMERGENCY PLEASE NOTIFY _____ PHONE_____

**History of Chief Complaint**

List Disease or Location of Pain _____ For How Long _____

Have you had this Health Problem or Similar Condition Before? Yes___ No___ If Yes, WHEN? _____

How was it treated?_____

Did that solve the problem? Yes No Made it better? _____ Made it worse? _____ Other _____

Is It Getting: Better ___ Same ___ Worse ___ Interfering with: Sleep _____ Work _____ Normal Routine _____

What makes it better? _____ What makes it worse? _____

Describe the pain if pain is present (I.E. burning, sharp, dull, aching, etc.)_____

How long does the pain last? Seconds _____ Minutes _____ Hours _____ Days _____ Other_____

Is the pain: Mild ___ Moderate ___ Severe ___ Does the pain radiate(move from the original area of pain)? Yes__ No__ IF Yes, where does the pain move to? _____

Does the pain occur with specific movements or at a certain time of day? Yes ___ No ___ If Yes, Please explain

_____

***PAYMENT IS REQUIRED AT TIME OF SERVICE. MOST INSURANCE COMPANIES BENEFITS DO NOT COVER ACUPUNCTURE. PLEASE VERIFY YOUR BENEFITS AND NOTIFY US IN THE EVENT YOUR INSURANCE POLICY PROVIDES BENEFIT.***

***I UNDERSTAND THE ABOVE AND AGREE THAT I AM RESPONSIBLE FOR ALL CHARGES.***

Patient's SIGNATURE:_____ DATE:_____

Physician's SIGNATURE:_____ DATE:_____

# Our Insurance & Financial Policy

We will gladly accept your insurance assignment in lieu of payment from you for your care and treatment in our office. The following policy prevails:

If your policy is verified and proven to cover chiropractic services, it is the policy of this office to accept assignment on part of your bill. This enables you to have less out-of-pocket expense. If it has not been verified, fees for services rendered are expected to be paid at the time of service.

## HERE'S HOW IT WORKS!

1. You are responsible for your deductible **in full**.
2. Thereafter, on each visit, you pay that portion not covered by your insurance company. You may also choose to make one weekly payment for your convenience.
3. You also pay that portion of any re-examination, comparative x-rays, or additional procedures not covered by your insurance company.
4. We will collect the balance from your insurance company.

For those patients who do not have insurance coverage for our services, you may pay at the time of service by: MASTERCARD, VISA, PERSONAL CHECK or CASH. **All fees for services rendered are expected to be paid at the time of service unless prior financial arrangements have been made.** **THERE IS A $25 SERVICE CHARGE FOR RETURNED CHECKS.**

If your health problem is the result of an **automobile accident**, we will gladly bill all charges to your auto insurance after coverage has been verified. You must present all automobile insurance information at the time of your initial visit.

If your health problem is the result of a **work-related injury**, please let us know before you see the doctor. State law is specific on how we must bill our charges.

**IF YOU HAVE ANY QUESTIONS CONCERNING OUR INSURANCE & FINANCIAL POLICY, PLEASE DO NOT HESITATE TO SPEAK TO US.**

I have read and understand the above policy. I understand that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges. I further agree that should it be necessary for Hankison Family Chiropractic, Inc. to it's agents to employ collection and/or legal counsel, I hereby agree that I am responsible for collection charges incurred, which will be added to my bill.

_____ _____

Patient / Parent (Guardian) Signature Date

## ASSIGNMENT OF BENEFITS:

I authorize and direct that payment be made directly to: Hankison Family Chiropractic, Inc. James F. Hankison, DC, or Heather R. Hankison, DC, 1455 S Ferdon Blvd Ste.D2, Crestview, FL, 32536 for any and all insurance benefits or reimbursement for services rendered by them which amounts would otherwise be payable to me under any insurance or pre-paid health care plan.

_____ _____

Patient/Parent (Guardian) Signature Date

## RELEASE OF INFORMATION:

I authorize the release of any information concerning my health care services to my insurance companies, pre-paid health plan or Medicare/Medicaid.

_____ _____

Patient/Parent (Guardian) Signature Date