

Robinson Family Wellness
2140 Norcor Ave
Suite D
Coralville, Ia. 52241
(319) 354-4186

Confidential Patient Information

First Name _____ Last Name _____ DOB ___/___/___ Age _____ Sex M / F

Street Address _____ SSN _____

City, St Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

Occupation _____ Employer _____

Marital Status: M / S / W / D / Sep. Children: Name/Age _____

Spouse _____ DOB ___/___/___ Occupation _____

Emergency Contact: Name _____ Phone # _____ Relation: _____

Who may we thank for referring you to our office? _____

Who is responsible for bill? Self Parent Work Comp Auto Ins. Personal Ins.

The following people are allowed access to my health information:

Would you like to receive our monthly E-newsletter: Yes No E-mail: _____

Your Health profile

Why this form is important:

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to off you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Addressing The issue that brought you to the Office

If you have no symptoms or complaints, and are here for wellness services, please check here ___
"Wish to have Chiropractic Wellness Services" and skip to "Family Health Profile" Others need to briefly describe the
chief area of complaint, including the effect it has had on your life.

Reason for consulting our office?: _____

When did this condition begin? _____

Name of other Dr.'s seen for this _____

Symptoms: come and go came on gradually came on suddenly (date: _____)

Symptoms have persisted for: days weeks months years

Symptoms interfere with _____

What activities make symptoms worse? _____

What activities make symptoms better? _____

Medications you are currently taking: _____

Medications recommended but not taking at present _____

Do/ Did you smoke: Y / N

On a scale of 1 – 10 describe you stress level

Do / Did you drink Alcohol Y / N

(1 = none / 10 = Extreme)

Did you Play youth sports Y / N

Occupational _____

Have you had any Surgeries Y / N

Personal _____

Have you been involved in any car accidents Y / N

Are you pregnant? Y / N

On a scale of poor, Good, Excellent describe your:

Diet _____ Exercise _____ Sleep _____ General Health _____

Other Health History

Date of last physical exam _____ Date of last physician visit _____

Reason _____ Dr.'s Name: _____

Date of last X-Rays _____ Where? _____ Of What? _____

Previous chiropractic care? Y / N Dr.'s Name/Date _____

Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and
loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____

Spouse _____

Parent _____

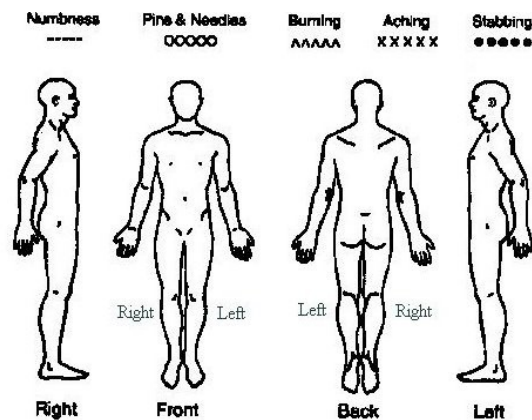
Siblings _____

Others _____

Please complete the following:

- | | | | | |
|---|--|-----|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | L R | <input type="checkbox"/> Tingling in Arm | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Shoulder Pain | O O | <input type="checkbox"/> Tingling in Leg | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Arm Pain | O O | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Elbow Pain | O O | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Wrist Pain | O O | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Hand Pain | O O | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Hip Pain | O O | <input type="checkbox"/> Depression | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Leg Pain | O O | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Knee Pain | O O | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Ankle Pain | O O | <input type="checkbox"/> Fainting | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Foot Pain | | <input type="checkbox"/> Loss of Smell | |

Shade areas to indicate location of discomfort:



Robinson Family Wellness Privacy Policy

I consent to the use or disclosure of my protected health information by Robinson Family Wellness for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Robinson Family Wellness. I understand that diagnosis or treatment of me by my physician(s) at Robinson Family Wellness may be conditional upon my consent as evidenced by my signature on this document. I also understand that Robinson Family Wellness will only release my protected health information to outside sources that have a specific signed release. Therefore we do not rent or sell your personal information to any outside sources.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Robinson Family Wellness is not required to agree to the restrictions that I may request. However, if Robinson Family Wellness agrees to a restriction that I request, the restriction is binding on Robinson Family Wellness and my physician(s) at Robinson Family Wellness

I have the right to revoke this consent, in writing, at any time, except to the extent that my physician(s) at Robinson Family Wellness or Robinson Family Wellness has taken action in reliance on this consent.

My “protected health information” means health information collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse, this includes my demographic information. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Signature of Patient or Guardian

Printed Name of Patient or Guardian

Date

Robinson Family Wellness Patient Financial Policy

The goal of Robinson Family Wellness is to render care within our realm of expertise to stimulate your innate ability to heal. We will give 100% of our energy to accomplish this and do our best to prevent financial constraints from interfering with your ability to receive care. To prevent misunderstandings about the financial aspects of care, the following discloses our financial policy.

PATIENTS WITH HEALTH INSURANCE COVERAGE

During your visit with us, we will verify your insurance coverage to see if chiropractic (and if necessary, out-of-network) care is covered and any limitations that exist. We will explain this to you, and then bill the insurance for the services provided. You are expected to pay your "co-pay" or the portion that your insurance doesn't cover **on the date of service**. If, for some reason, your insurance does not pay for a particular visit, those charges are then your responsibility. It is therefore prudent for you to understand your insurance policy and contact your insurance promptly with any questions or problems. However, we do reserve the right to no longer bill your insurance company, if that company is unreasonably difficult to work with.

PATIENTS PAYING OUT OF POCKET/ "CASH" PATIENTS

Cash, checks, and credit cards are accepted and payment is expected at the time of service. In this case, we offer a "**date of service discount**", due to the reduced administrative cost and handling. However, this does not include supplies or supplements. Legally, we can only grant this discount if the patient pays **prior to or on the day** of service. If you are unable to pay at the time of service, we will be unable to give you the discount and you will be charged the full price due to the administrative costs and handling of your account.

PATIENTS WITH AUTO/WORKER'S COMPENSATION CLAIMS

For patients under care relative to an automobile accident or injury on the job, insurance will cover the cost of care in most cases. We are required to bill *your* auto insurance (or the insurance of the driver of the vehicle in which you were riding) or your WC insurance. Nutritional supplements and some orthopedic equipment, if recommended, are not paid for by insurance and are the patient's financial responsibility. If/when your insurance discontinues paying for your treatment, **you are then responsible for payment** of your care. If necessary, a monthly payment plan may be arranged. If you decide to get legal aid, we will hold payment until settlement of your claim as long as you are using one of the attorneys we strongly recommend.

CANCELLATION POLICY

If you must miss your scheduled appointment, it is best to reschedule as soon as possible. We have a **24 hour cancellation policy**. A fee equal to the fee of the appointment will be incurred if we do not receive advanced notification of at least 24 hours. Insurance does not cover this fee. It will be your responsibility.

OUTSTANDING BALANCE POLICY

Patients will receive a monthly fee of \$5 if their account has a balance that is 90+ days overdue and no payments are being made on it. Overdue accounts will not receive this fee if regular payments are being made to the account. If no payment is made after 180+ days, we unfortunately will need to send the account to collections. Please speak to the office manager if you have any concerns regarding this policy.

I have been informed of and understand this financial policy and agree to it's terms. I understand that unless specific arrangements are made with Robinson Family Wellness, I am responsible for any balance acquired on this account. I understand that if I discontinue care, all charges are due and payable immediately.

Patient's Signature

Date

Patient's Printed Name

Auto Accident or Work Related Injury?

If yes, Please Complete The Following Questions:

Date of Accident _____ Time _____ am pm Location _____

Circumstance: Auto Accident On The Job Injury Other _____

Did you report injury to your employer? Y / N

Describe accident: _____

If Auto Related, Fill Out Box Below:

Were you? <input type="checkbox"/> Driver <input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger - Position: <input type="checkbox"/> Front <input type="checkbox"/> R. Rear <input type="checkbox"/> L. Rear
Was the impact from? <input type="checkbox"/> Front <input type="checkbox"/> R. Side <input type="checkbox"/> L. Side <input type="checkbox"/> Rear
Where were you looking? <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Straight Ahead
Were hands on wheel? Y / N Foot on brake? Y / N Braced for impact? Y / N
Was there a headrest? Y / N Seat belt on? Y / N Shoulder harness on? Y / N
Shoulder Lap Combination? Y / N Shoulder only? Y / N
Where were you in the car after impact? _____ Did you strike anything in car? Y / N
If yes, specify: <input type="checkbox"/> Steering Wheel <input type="checkbox"/> Dashboard <input type="checkbox"/> Windshield <input type="checkbox"/> Side Door <input type="checkbox"/> Other _____
What <u>specific</u> body part(s) hit above car part? _____
What was the make, model, and year of your vehicle? _____
What was the make, model of the vehicle that hit you or you hit? _____
Was there police at scene? Y / N Citation Issued? Y / N To Whom? _____

Immediately following the accident, how did you feel? _____

Has this been injured before? Y / N Describe when? _____

Were you unconscious? Y / N For how long? _____

Did you go to a hospital/emergency center? Y / N Where and when? _____

How did you get there? _____ Attending Dr.? _____

Were X-Rays taken? Y / N Of what? _____ Diagnosis? _____

Treatment rendered? _____ Released same day Y / N If no, when? _____

Recommendations/home care _____

Referral to? Chiropractor Medical Dr. Physical Therapist Other _____

Have you seen any other Dr. for this accident? Y / N Dr.'s Name: _____

Diagnosis _____ Treatment _____

Recommendations _____ Additional X-Rays taken? Y / N Of where? _____

Have you lost any time from work because of accident? Y / N Dates: _____ to _____

Totally disabled from _____ to _____ Partially disabled from _____ to _____

Insurance Companies Involved

Name of my auto ins. _____ Phone #: _____ Claim # _____

Responsible party's ins. _____ Phone #: _____ Claim # _____

Have you been contacted by an ins. Representative on this claim? Y / N

Do you have an attorney on this case? Y / N Name _____ Phone # _____