TIESZEN
CHIROPRACTIC & MASSAGE

Preferred Name: _____

Please allow a few minutes at each visit for us to evaluate your progress and collect any necessary documentation for your billing agreement with us.

Note if injury caused by: Car Accident Job Slip & Fall N/A

Legal Name (first/last): _____

Social Security #_____ Date of Birth _____ Male Female

Martial Status _____

Address _____

City/State/Zip _____

Contact Phone #1 _____ #2 _____ #3 _____

E-mail _____

Employment: Full-Time Part-Time Self-Employed Student N/A

What specific improvements are you seeking from treatment?

_____

_____

Do you smoke? _____ Chew? _____ Drink?_____

How did you hear about us?

_____

Did you see another doctor for this condition? _____
If yes, complete the Medical Records Release form available at the front desk.

When did you last receive an adjustment from a doctor of chiropractic? _____

D.C. Name/Location _____

Did a doctor refer you directly to our clinic for care? _____
If yes, please allow our front desk to obtain a copy of your medical referral or RX. A summary of your care will be sent to your primary provider.

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CONSENT FOR TREATMENT

I understand it is the practice of Dr. Neil Tieszen to evaluate, examine and oversee patient care and treatment. I authorize the staff of Tieszen Chiropractic to render whatever services are necessary for the care of myself and/or my family, and I agree to assume all financial obligations incurred for such care.

DATE: _____ SIGNATURE: _____

CANCELLATION POLICY

In order for Tieszen Chiropractic to function efficiently and effectively cancellations must be made 24 hours prior to scheduled appointments. Failure to cancel a scheduled appointment within the required time will result in a $40 cancellation fee to be charged to your patient account. This fee will also be charged for missed appointments. Exceptions will only be made at the discretion of the doctor and office staff. I have read, agree to, and understand Tieszen Chiropractic's cancellation policy.

DATE: _____ SIGNATURE: _____

Mark "same" or "N/A" if not applicable. (If you have more than two insurances, use the bottom of a second form.)

Name of Policy Holder _____ Relation to You _____

Primary Policy Holder Date of Birth _____

Primary Policy Holder SSN# _____

Primary Policy Holder Employer Name & Location _____

Name of Secondary Policy Holder _____ Relation to You _____

Secondary Policy Holder Date of Birth _____

Secondary Policy Holder SSN# _____

Secondary Policy Holder Employer Name & Location _____

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Consent for Purposes of Treatment, Payment & Healthcare Operations
HIPAA Notice

I consent to the use or disclosure of my protected health information by Tieszen Chiropractic for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Tieszen Chiropractic. I understand that analysis, diagnosis or treatment of me by Tieszen Chiropractic may be conditioned upon my consent as evidenced by my signature below.

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 healthcare operations of the practice. If I request a restriction, Tieszen Chiropractic may or may not agree to a restriction that I request, the restriction is binding on Tieszen Chiropractic. I have the right to revoke this consent, in writing, at any time, except to the extent that Tieszen Chiropractic has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic 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 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.

The privacy practices of Tieszen Chiropractic are as follows; our patients' documents will not be released outside of our office without express agreement from the patient. The documents that can be released with permission from the patient are for purposes of treatment and billing compliance with an insurance company. Any request for the release of records must be signed in witness of a Tieszen Chiropractic employee. Each employee at Tieszen Chiropractic is informed on HIPAA laws and regulations.

Tieszen Chiropractic reserves the right to change the privacy practices that are described above. I may obtain a revised notice of privacy practices by calling the office of Tieszen Chiropractic and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

PATIENT SIGNATURE (or RESPONSIBLE PARTY) _____ DATE _____

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Assignment

By signing below I acknowledge that I have read the Financial Information Form and understand the policies and my responsibilities. I also authorize Neil D. Tieszen, DC, to release medical records and information to my insurance company(s) in order to assist me in recovering my costs for care, and it also authorized and directs the insurance company(s) and/or the attorney(s) to pay benefits directly to Dr. Neil. This also authorizes Dr. Neil to release records and information, and to consult with other individuals or health care providers as necessary to ensure that I receive the best health care possible or to recover my costs. I understand that I am responsible for any amount not covered for any reason, as well as any fees associated with collecting that balance. I understand that charges not paid within 30 days or arranged to be paid through other payment plans may be subject to a monthly finance charge of 1.5%, or as allowed by law, and that pertinent information ay be released to a collection agency or credit bureau to accomplish that collection. I also understand that a copy of this form is just as valid as the original.

Lien

This form also gives notice that I am authorizing a Lien to be executed in accordance with AS 34.35.450 when appropriate by Neil D. Tieszen, DC. To secure payment or services rendered to me. I acknowledge that I have or am about to receive treatment for injuries or conditions as described in my patient history and other places, and am authorizing Neil D. Tieszen, DC to claim a lien upon those individual(s) responsible for causing these injuries or conditions, and any other person liable for the injury or condition or obligated to compensate me on account of these injuries or conditions. These services were or will be rendered on dates set out in the billing statements, or as provided below:

Dates of Claim between:_____and_____
Amount Owed:_____
Description of Services:_____

I agree that this Authorization of Lien is not valid after 90 days of my discharge from treatment, but that all of the other provisions will continue to apply. I also attest to the fact that I have read all of the above and understand it, ad agree to its provisions, I hereby authorize Neil D. Tieszen to supply the information above when appropriate, and have it appropriately recorded on my behalf.

_____ _____
PATIENT SIGNATURE (or RESPONSIBLE PARTY) DATE

_____
PRINTED NAME

Payment for Services

Medical Release & Payment Authorization: I hereby authorize Tieszen Chiropractic & Massage to furnish information to insurance carriers concerning my illness/injury and treatments and hereby assign to the clinic all payments for medical services rendered to myself and my dependents. (_____ Initial)

PATIENT RESPONSIBILITY

- Insurance coverage is not a guarantee of payment. (_____ Initial)
- We will verify your benefits. This is not a guarantee of coverage, benefits, or payment (_____Initial)
- We will bill your insurance if you present your insurance card(s) at the time of your appointment. It is important for you to be aware that we are not contracted with every insurance carrier. This means that you are responsible for monitoring the processes of your insurance company to make certain your claim is processed in a timely manner, for contacting them if you have questions as to how your claim was processed, and that you are ultimately responsible for payment of services rendered. (_____ Initial)
- Any co-payments, deductibles, or "patient responsibility" percentages must be paid at the time of service. (_____ Initial)
- You will receive a statement for any remaining balance after all applicable insurance claims have been paid. That balance is due in full at that time. (_____ Initial)

We also highly recommend that you research your insurance benefits prior to your visit, as there could be reasons why your insurance may not pay for your visit. These reasons might include the following:

- Your deductible has not been met.
- You have not received the proper referral or preauthorization for the visit or services. If your insurance requires preauthorization, it is your responsibility to obtain it before the visit or services are performed.
- Remember, preauthorization is not a guarantee of payment.
- The services or procedures are not covered by your insurance. We will inform you when we know a treatment or procedure is not covered, but many times it is not possible for us to know with certainty, as this varies greatly among insurance companies, and because they will not make a final determination until they have received the claim. If there is an uncertainty about coverage, we will be happy to provide you with an estimate of your fees before treatment is given. You are responsible to pay for the non-covered services at the time of your visit.

PAYMENT OPTIONS

We accept cash, checks, and all major credit cards. If payment in check form is returned to us because of insufficient funds, you will be charged a $25 fee.

When we are billing insurance for you, you have the following payment options:

- You may pay your first visit in full at the time of service. (We will refund or credit your account if your insurance pays more than expected.)
- You may pay your co-pay, co-insurance,or deductible in full. If we have verified your benefits.
- You may use our Tieszen Easy Pay program and have a credit card on file that will be billed monthly for any balance that remains on your account. We will contact you before we run your card, per your request. (Please ask the front desk for details.)

Important: If your account should ever become 120+ days overdue, without a payment agreement on file, your account will be turned over to a collection agency. Accounts that have been turned over to collections are responsible for all late fees assessed by Tieszen Chiropractic and Cornerstone Credit Services; this includes a 35% collection fee.

By my signature below, I acknowledge I have read and that I understand the above statements and am willing to accept responsibility to pay for services rendered if my insurance does not cover them. This authorization is not limited in time.

_____ _____

PATIENT SIGNATURE (or RESPONSIBLE PARTY) DATE

Patient History

Date of onset:_____

Since onset of symptoms are you feeling: □ Better □ Worse □ Same

Do you hurt in the □ Morning or □ Evening

Is your pain □ Constant □ Intermittent □ Other_____

What if anything relieves your condition? _____

How did the onset of your condition occur? _____

General Symptoms (Check box if applies)
□Nervous/Anxious
□Fatigue
□Stress
□Vision Changes
□Other_____
□Loss of Sleep
□Menopausal
□PMS
□Fainting
□Difficulty Concentrating
□Tremors
□Ringing in ears
□Loss of Memory
□Dizziness
□Palpitations
□Loss of Balance
□Digestive Changes

Head (Check box if applies)
□Headache □Facial Pain □Running nose
□Migraine □Pain behind eyes □Jaw Pain

(Check boxes below if you have pain with any of the following or if applies to your condition)

Neck

□L	Turning	R□	□L	Whiplash	R□
□L	Bending	R□	□L	Disc Bulge	R□
□L	Stiffness	R□	□L	Sprain/Strain	R□
□L	Spasm	R□	□L	Arthritis	R□
□L	Inflammation	R□	□L	Radiating Pain	R□

Mid-Back

□L	Turning	R□	□L	Whiplash	R□
□L	Bending	R□	□L	Disc Bulge	R□
□L	Stiffness	R□	□L	Sprain/Strain	R□
□L	Spasm	R□	□L	Arthritis	R□
□L	Inflammation	R□	□L	Radiating Pain	R□

Low-Back

□L	Turning	R□	□L	Whiplash	R□
□L	Bending	R□	□L	Disc Bulge	R□
□L	Stiffness	R□	□L	Sprain/Strain	R□
□L	Spasm	R□	□L	Arthritis	R□
□L	Inflammation	R□	□L	Radiating Pain	R□

Shoulder

□L	Overhead Movement	R□
□L	Frozen	R□
□L	Turning	R□
□L	Disc Bulge	R□
□L	Stiffness	R□
□L	Sprain/Strain	R□
□L	Inflammation	R□
□L	Arthritis	R□
□L	Rotator Cuff Syndrome	R□
□L	Radiating Pain	R□

Elbow

□L	Bending	R□
□L	Stiffness	R□
□L	Numbness/Tingling	R□
□L	Straightening	R□
□L	Inflammation	R□

Wrist

□L	Bending	R□
□L	Stiffness	R□
□L	Numbness/Tingling	R□
□L	Straightening	R□
□L	Inflammation	R□
□L	Carpal Tunnel	R□

Thigh/Hip

□L	Stiffness	R□
□L	Arthritis	R□
□L	Numbness/Tingling	R□

Ankle

□L	Stiffness	R□
□L	Arthritis	R□
□L	Numbness/Tingling	R□