Arbor Vitae
Chiropractic Clinic

AUTHORIZATIONS TO TREAT AND ACCEPTANCE OF FINANCIAL RESPONSIBILITY

Authorization to Treat: I authorize Arbor Vitae P.C., Dr. Lubkeman or his designee to treat conditions that are presented in the course of consultation, examination or care in this clinic. If I am signing this as a parent or guardian of a minor child or other person unable to give legal consent, I hereby authorize the treatment of said individual by the entities or persons above.

Acceptance of Financial Responsibility: I understand that I am personally liable for all charges incurred in this office for services rendered to me or the person I represent. Insurance is an agreement between me and the insurance company. The doctor's office will file and accept payment from insurance as a service to me but I am, ultimately, responsible for any amount the insurance company does not pay including co-pays, deductibles, and insurance denials. If payment is denied or only part of the payment is reduced due to deductible or other insurance company restriction, I also agree to be responsible for the remaining portion of the billable services accrued as a result of receiving treatment in this clinic. I understand that I am entitled to, as part of this agreement, a complete accounting of all services billed.

Medicare, Medicaid, and other insurance companies only pay for a limited number of adjustments per year. Some insurances', including Medicare do not pay for x-rays when ordered by a chiropractor. Some, including Medicare and Medicaid, do not pay for examinations (which they require before treatment can be authorized) and other therapies in certain situations. The doctor's office will do its best to keep me informed of services performed or to be performed that my insurance does not cover so I can make an educated decision about the necessity of performing these services in my case.

Authorization to Bill Insurance Companies: By signing this agreement, I do hereby authorize Arbor Vitae P.C, Dr. Roy Lubkeman or his designee to release any medical or other information necessary to process insurance claims for services rendered in this office. I also request payment of government benefits to Dr. Lubkeman or Arbor Vitae P.C. as the patient/insured's designee. (Box 12 & 13 of Form CMS-1500)

I have read and understand the terms of this agreement. I agree to be personally and fully responsible financially for charges accrued in the course of my treatment in this office. I am over 18 years of age and understand this is a legally binding agreement.

Dr Roy Lubkeman

Signature	Date	Provider Name

Patient (if other than signatory)	Age

Privacy Statement: Your privacy is important to us and we will take every effort to preserve your privacy and your private information. Health Information is protected under the HIPAA act and we will not release your private information to any unauthorized entity without your written permission/authorization. While the HIPAA laws allow sharing of information between treating physicians without authorization, it is our policy to seek a higher standard and require authorization for transmission of information to any other clinical entity. The insurance company and clearinghouse providers are also held to the same privacy standards that apply to all healthcare facilities and providers.

Patient or Parent Signature: _____Date: _____

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NEW PATIENT INFORMATION

Welcome to our office! Please complete all questions below.

Title: (Circle) Mr Mrs Ms Miss Dr Prof Rev
Nickname: _____
First Name: _____
Middle Name: _____
Last Name: _____
Suffix: _____
Address: _____
City: _____ State: ___Zip: _____
Primary Phone: _____
Mobile Phone: _____
e-mail Address: _____
Can we contact you by e-mail? _____
Birth Date: _____/_____/_____
Gender: ❑ Male ❑ Female
Marital Status: ❑Single ❑ Married ☑Widowed ❑Divorced ❑Legally Separated
Social Security Number: _____
Employment Status: _____
Employer: _____
Occupation: _____
Employer Address: _____
City: _____ State: ___ Zip: _____
Work Phone: _____
Fax/Work E-Mail_____
Race: _____
Multi-Racial: Yes No
Ethnicity: _____
Preferred Language: _____

How did you hear about the office? _____

Spouse, Parent, or responsible party information.

Name: _____
Birth Date: ___/___/____ SSN: _____
Employer: _____
Mobile Phone: _____
Children's names and ages: _____

Do you have Health Insurance? ❑Yes ❑No
Insurance Co: _____
Who is the guarantor? _____ DOB: __/__/_____

Please provide copy of Insurance Card.

Payment is to be made at the completion of each visit for copays or cash payments.
Method of payment for first visit: ❑Cash ❑Check ❑Credit Card

Is your pain the result of an: Auto Accident? ❑**No** ❑Yes Work Injury? ❑**No** ❑Yes _____
Is there currently any legal action pending, involving this injury? ❑**No** ❑Yes What? _____
For Women: Last Menstrual Period: _____ Are you pregnant? _____ Due? _____

<u>What are your expectations in your treatment program</u>?

❑Pain relief care only ❑Rehabilitate the spine (last longer)
❑Maintenance (the first two plus keep me healthier)
❑ Optimization (I want my health to continue to improve)

The above information is true to the best of my knowledge. I authorize Dr. Lubkeman to provide treatment to the above named individual for conditions that fall under the scope of chiropractic care.

Patient or Parent Signature: _____Date: _____

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CURRENT HEALTH CONDIT ION

Main Complaint _____
Rate Pain on a scale of: (circle, 1-mild to 10 severe) 1 2 3 4 5 6 7 8 9 10
Rate your pain over the past week: 1 2 3 4 5 6 7 8 9 10
How did the pain start? _____
When did the pain start? _____Have you had it before? No Yes When?_____
Is the pain worse in the? ❑ Morning ❑ Afternoon ❑Night ❑No Difference
Does the Pain Radiate? No Yes Where? _____
How often do you have the pain? 0-25% 25-50% 50-75% 75-100% of the (circle): Day Week Month

Quality (what type of pain is it?)

❑Dull	❑Sharp	❑Throbbing	❑Burning	❑Deep	❑Aching
❑Tingling	❑Stabbing	❑Cramping	❑Numbness	❑Radiating	❑Stiffness

Aggravating Factors

❑Sitting	❑Standing	❑Walking	❑Bending	❑Stooping	☑Lifting
❑Sleeping	❑Sneezing	❑Coughing	❑Straining	❑Reaching	❑Twisting
❑Looking up	❑Looking Down	❑Movement	❑Rest	❑ Lying on back	❑Driving
❑Typing	❑Scooping	❑House Chores	❑Exercise	❑Lying on stomach	❑Stair Stepping

Relieving Factors

❑Sitting	❑Standing	❑Lying	❑Knees Bent up	❑Support
❑No Movement	❑Movement	❑Heat	❑Ice	❑Topical Analgesic
❑Ibuprofen	❑Medication	❑Rest	❑Adjustments	❑Stretching/ Exercise

Secondary Complaint _____
Rate Pain on a scale of: (circle, 1-mild to 10 severe) 1 2 3 4 5 6 7 8 9 10
Rate your pain over the past week: 1 2 3 4 5 6 7 8 9 10
How did the pain start? _____
When did the pain start? _____Have you had it before? No Yes When?_____
Is the pain worse in the? ❑ Morning ❑ Afternoon ❑Night ❑No Difference
Does the Pain Radiate? No Yes Where? _____
How often do you have the pain? 0-25% 25-50% 50-75% 75-100% of the (circle): Day Week Month

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❑Looking up	❑Looking Down	❑Movement	❑Rest	❑ Lying on back	❑Driving
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Relieving Factors

❑Sitting	❑Standing	❑Lying	❑Knees Bent up	❑Support
❑No Movement	❑Movement	❑Heat	❑Ice	❑Topical Analgesic
❑Ibuprofen	❑Medication	❑Rest	❑Adjustments	❑Stretching/ Exercise

Do your symptoms interfere with daily activities? (not at all), (a bit), (moderately), (a lot),(extremely)
Other Doctors Seen for these conditions: _____ When: _____
Recommendations or Treatment: _____
Please note additional health concerns/complaints in order of seriousness. Rate pain on scale of 1-10
1. _____
2. _____

In general, how good is your health right now? 1– Excellent 2– Very Good 3– Good 4– Fair 5 – Poor

I hereby authorize Dr. Lubkeman to treat the above conditions.

Patient or Parent Signature: _____Date: _____

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Are you taking prescription medications now? ☑Yes ☑No Over the counter medications? ☑Yes ☑No
List(Name/Dosage): _____

_____

Please list any Vitamins, Minerals, Herbs, or Nutritional Products that you are currently taking:

_____

Past Health History

Allergies: 1. Date of Onset_____ Allergy _____
Reaction Description: _____
2. Date of Onset_____ Allergy _____
Reaction Description: _____

Family History: Major conditions of family members:
Relationship: _____ Condition:_____
Relationship: _____ Condition: _____
Relationship: _____ Condition: _____

Hospitalizations: Date: __/___/____ Reason:_____ Hospital: _____
Date: __/__/_____ Reason: _____ Hospital: _____
Date: __/__/_____ Reason: _____ Hospital: _____

Major Surgery/ Date: _____/ _____ _____/ _____ _____/ _____
Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery Broken Bones
Hysterectomy Ear Tubes Child Birth Other: _____ In or Out Pt. _____

Major Accidents or Falls: _____ When: _____Treatment: _____

Immunization/Date: _____/_____, _____/_____, _____/_____, _____/_____

Laboratory Test:_____ Date Ordered: _____ Date Completed: _____
Result:_____

Laboratory Test:_____ Date Ordered: _____ Date Completed: _____
Result:_____

Recreational History: Activity: _____ Frequency _____ Difficulty: 1 2 3 4 5 6 7 8 9 10
Activity: _____ Frequency _____ Difficulty: 1 2 3 4 5 6 7 8 9 10
Activity: _____ Frequency _____ Difficulty: 1 2 3 4 5 6 7 8 9 10

Smoking History: Status: ❑Everyday ❑Occasional ❑ Former Smoker ❑Never ❑Unknown
Years Smoked: _____ Packs per Day: _____ Years Quit: _____
Level of Interest in Quitting: 0 1 2 3 4 5 6 7 8 9 10

Habits	Heavy	Moderate	Light	None
Alcohol	❑	❑	❑	❑
Coffee/Tea	❑	❑	❑	❑
Pop/Soda	❑	❑	❑	❑
Water	❑	❑	❑	❑
Sleep	❑	❑	❑	❑
Pain Relievers	❑	❑	❑	❑
Recreational Drug Use	❑	❑	❑	❑
Exercise	❑	❑	❑	❑

Healthy Eating Rank: (circle: 1=Bad to 10=Good) 1 2 3 4 5 6 7 8 9 10
Physical Stress levels (circle: 1=Mild to 10=Severe) 1 2 3 4 5 6 7 8 9 10
Major Stressor: _____
Emotional Stress levels (circle: 1=Mild to 10=Severe) 1 2 3 4 5 6 7 8 9 10
Main Stressor: _____

Printed Name: _____

Patient or Parent Signature: _____Date: _____