Mueller Chiropractic

Confidential Patient Information

710 Breckenridge Ln., Suite 201
Louisville, KY 40207
502-897-5181 Fax: 502-897-5122

Today's Date:____________________Your Social Security Number_____________________________________

Name:____________________________Home Phone:_____________________ Alt.Phone:___________________

Address:_____________________________ City:____________________ State:________ Zip:________________

Date of Birth:___________ Marital Status:_____Occupation:_________________ Email_____________________

Employer:______________________ Work Phone:__________________ Referred by:______________________

Do you have Health Insurance? Y N   Insurance company?____

When was your last examination?_______________________ Have you ever suffered from any of the following:

Headache Y N   Low Back Pain Y N   Heart Trouble Y N Dizziness Y N   Cancer Y N   Neck Pain Y N

Please list any and all surgeries you have undergone:____

____

Please list any and all medications you take now:____

____

Please list remarkable family health history I.E. parents or siblings, aunts, and uncles who have had strokes, heart attacks, cancer, diabetes, etc.____

____

Why are you consulting us at this time?____

How long have you had these issues?____

Is your health better, same or worse than it was this time last year?____________________________________

List other doctors you have seen for this same condition:____

____

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and me. I understand that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care, I will immediately settle any outstanding balance I have through credit extended to me for any and all professional services rendered to that point.

Patient's Signature:____ Date:___________________

Guardian's Signature (if patient is a minor)______________________________ Date:___________________

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Craig A. Mueller, DC   Steven Tinlin, DC

Insurance Verification Form

If you would like to use you health insurance to settle your account in our office, you will need to call your insurance carrier to verify your coverage prior to receiving care.

Simply call the phone number on your insurance card and ask the clerk the standard questions listed below. If you would like someone on our staff to call on your behalf we will gladly do so; there is a fee for this service of $20, which we charge on the initial visit.

Complete this section before calling:

Patient Name: ___________________________________ DOB______________________
Policy ID: ______________________________________ Group # ____________________
Policy Holder: __________________________________ DOB ______________________
Insurance Co: ___________________________________ Phone #____________________

Ask these questions:

Is Mueller Chiropractic, IN NETWORK or OUT of NETWORK with my insurance?

Does my plan have a pre-existing clause? YES or NO

How many Chiropractic visits does my policy cover? ________

Do I have to have my visits pre-authorized? YES or NO

How many visits have been used? __________

Regarding My Deductible:

What is my individual deductible? $______ How much have I met as of today? $_______

What is my family deductible? $ ________ How much have I met as of today? $ ______

Does my policy limit my annual Out of Pocket Expense (OPE)? YES of NO

What is the individual OPE amount? $_______ How much has been met $ _________

What is the family’s annual OPE? $ _________ How much has been met$ ___________

Is my policy set up on a CALENDAR year or PLAN year? (Circle One)

What is my co-pay or co-insurance? $__________

After I pay my co-pay or co-insurance is there a specific percentage of the covered charges that my policy pays? What is that percentage? _____%

On the Initial Visit:

Is my initial office visit SEPARATE from or PART of my total chiropractic visits.

On my initial office visit do I pay my COPAY or CO-INSURANCE? (Circle one)

Does my payment for the initial office visit/exam go toward my deductible? YES or NO

What about Physical Therapy Modalities?

Does my plan cover therapeutic modalities? YES of NO. If so, how many? _____

Are these modalities COMBINED WITH or SEPARATE from my Chiropractic visits?

In Closing:

Insurance Reps Name: ____

Call Reference Number: ____

Verification Date: ____

Bring this information with you so our insurance staff may submit claims on your behalf efficiently.

Thank you for your cooperation. Your assistance allows us to focus on serving you better at affordable prices.

Sincerely,

Mueller Chiropractic

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710 Breckenridge Ln #210 . Louisville, KY 40207
Phone: 502-897-5181 . Fax 502-897-5122
Craig A. Mueller, DC Steven Tinlin, DC

INFORMED CONSENT TO CHIROPRACTIC CARE and ADMINISTRATIVE FEES

I hereby request and consent to the performance of Medical treatment and assessment, Chiropractic adjustments and rehabilitation procedures performed at Mueller Chiropractic & Physical Medicine and performed by the doctors listed above. I understand that treatment methods in this office vary from doctor to doctor and are based on my condition. I represent that I have come here for care at my own direction and by my own choice.

I have had the opportunity to discuss with the Doctors and /or with other office personnel the purpose and benefits of the services recommended in my case. I have had the opportunity to discuss any short or long-term consequences, favorable or unfavorable, to any therapy, including Class IV laser therapy, applied to me. I have had the opportunity to discuss alternative treatment of my condition and have personally decided that the care being offered here is reasonable as presented.

Though all therapies provided at MCPM, including Chiropractic adjustments and Class IV laser therapy to my brain and nervous system, are intended to improve one's health and vitality, I understand and am informed by means of this document that some risks exist when any treatment is intended to change bodily function. Risks may include (but are not limited to) fractures, disc injuries, dislocations, sprains and possible, and rarely strokes. Some treatments to ill or injured person may exceed the metabolic capacity of an individual. Every effort is made to insure the person is capable to receive what ever care is provided. I realize I have had ample opportunity to ask any doctor on this staff to outline potential risk in my case based on the findings of my evaluation.

In the course of my care or simply for health screening and examination, Infrared Imaging, not an anatomical test may be used. In that process any reference to anatomy refers to the thermal emission from the skin overlying that anatomy. Comments made in impressions or conclusion are speculative and not intended to rise to the level of a "diagnosis" but to provide insight into functional risk indicators that may aid the primary care physician in clinical decision making.

I understand that rehabilitation to brain, brain stem, spinal cord, muscles, joints, tendons and nerves as well as interpretation of thermal patterns on infrared imaging is not an exact science. I understand that reputable, well trained practitioners cannot fully guarantee results. No guarantee or assurance has been made by anyone at MCPM, nor is treatment by one doctor a reflection on or the responsibility of the others. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I hereby release, do not hold responsible and waive any liability concerning the diagnosis and or treatment of my condition from the doctors at Mueller Chiropractic & Physical Medicine. I hereby consent to the proposed treatment recommended on my report of findings and affirm that I have made full disclosure regarding all information that would influence my care or place the specific treating doctor at risk. I agree to hold the non-treating doctors harmless for my care.

Signature of Patient: ____ Date:

Signature of Parent: ____ Date:
(or Guardian/Spouse)

Witness Signature: ____Date: