WELCOME

ABOUT YOU

Today's Date:_____/_____/_____ File #_____
Name:_____
Preferred to be called:_____ ☐ Male ☐ Female
Birthdate:____/____/_____ Age:_____ SS#_____-___-_____
Street Address:_____
City:_____State:_____Zip:_____
Email:_____
Home Phone#: _____
Cell Phone #: _____
Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed
Spouse's Name:_____
Employer:_____
Employer's Address:_____
City:_____ State:_____ Zip:_____
Occupation:_____ Phone:_____
Referred by:_____

INSURANCE

Primary Insurance
Insured's Name:_____
DOB:_____ SSN:_____
Co. Name:_____
Member ID:_____
Group #:_____

Secondary Insurance
Insured's Name:_____
DOB:_____ SSN:_____
Co. Name:_____
Member ID:_____
Group #:_____

Medicare
Insured's Name:_____
DOB:_____ SSN:_____
Medicare ID:_____

Medigap Policy
Insured's Name:_____
DOB:_____ SSN:_____
Co. Name:_____
Member ID:_____
Group #:_____

REASON FOR VISIT

Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No
If so, please explain: _____
_____

The reason of this visit is a result of (Please circle): work / sports / auto / trauma / chronic
Please explain:_____
_____
_____

Please describe the pain and its location: _____
_____

When did the condition begin? _____/_____/_____
Is this condition getting worse? ☐ Yes ☐ No ☐Constant ☐ Comes and goes
Is this condition interfering with your (please circle): work / sleep / daily routine
If so, please explain: _____
_____

Have you had this or similar conditions in the past? ☐ Yes ☐ No
If so, please explain: _____
_____

Have you been treated by a Medical Physician for this condition? ☐ Yes ☐ No
If so, where? _____

IN EVENT OF EMERGENCY

Who should we contact?_____

Relation:_____

Home phone: _____

Cell phone:_____

Work phone:_____

ACCOUNT INFO EMERGENCY

Person ultimately responsible for account

Name:_____

Relation:_____

Billing Address:_____

City:_____ State:_____ Zip:_____

SSN:_____

Driver's License #:_____

Phone: _____ Cell:_____

HEALTH HISTORY

Are you taking any of the following medications?

☐ Nerve pills ☐ Pain killers(including aspirin) ☐ Muscle relaxers ☐ Stimulants ☐ Blood thinners ☐ Tranquilizers ☐Insulin ☐Other_____

Have you ever had any of the following diseases / medical conditions?

Y / N Heart Attack/Stroke	Y / N Heart surg./Pacemaker	Y / N Heart Murmur
Y / N Congenital Heart Defect	Y / N Mitrial Valve Prolapse	Y / N Artificial Valves
Y / N Alcohol / Drug Abuse	Y / N Venerial Disease	Y / N Hepatitis
Y / N HIV + / Aids	Y / N Shingles	Y / N Cancer
Y / N Frequent Neck Pain	Y / N Empysema / Glaucoma	Y / N Anemia
Y / N High/Low Blood Pressure	Y / N Psychiatric Problems	Y / N Rheumatic Fever
Y / N Severe/Frequent Headaches	Y / N Kidney Problems	Y / N Ulcers / Colitis
Y / N Fainting/Seizures/Epilepsy	Y / N Sinus Problems	Y / N Asthma
Y / N Diabetes / Tuberculosis	Y / N Difficulty Breathing	Y / N Chemotherapy
Y / N Lower Back Problems	Y / N Artificial bones / Joints	Y / N Arthritis

Please list any other serious medical condition(s) you have or have ever had: _____

_____

Please list anything to which you may be allergic:_____

_____

List previous surgeries / treatments with dates:_____

_____

List any **past** serious accidents with dates:_____

_____

Do you smoke? ☐ No ☐ Yes / how much?_____ How long?_____

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

What is the age of your mattress?_____ Is it comfortable? ☐ Yes ☐ No

For women: Are you taking birth control? ☐ Yes ☐ No

Are you pregnant? ☐ No ☐ Yes/How long?____ Are you nursing? ☐ Yes ☐ No

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. If it is necessary to send unpaid fees to collections, all fees incurred, including all attorney fees and 1.5% interest monthly will be the responsibility of the patient. If it is necessary to send unpaid fees to collections, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 25% of the debt, and all costs and expenses, including reasonably attorneys' fees, we incur in such collection efforts.

I will be paying today by ____ Cash ____ Check ____Credit Card ____ Care Credit

Patient's Signature _____ Date: _____

Premier Health Care, L.L.C.
Sean K. Branham D.C.

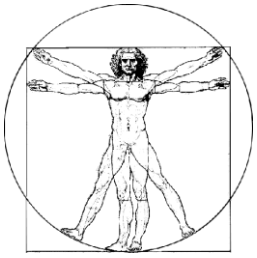
AUTHORIZATION FOR TREATMENT/ INFORMED CONSENT

I authorize the above named Dr. to administer treatment to me and to perform therapy and manipulation and I authorize such additional procedures, as the above named Dr. may consider desirable, on the basis of findings and determinations made during the course of my treatment. I authorize the above named Dr. to consult with other professionals concerning my care and treatment.

I understand that certain risks and possible complications can accompany spinal manipulation including but not limited to disc injury, fractured ribs, cerebrovascular accidents, and musculotendinous-ligamentous injury and that these have been explained to me and that I understand them.

Date_____ Patient Signature_____

Print Signature_____



Premier Health Care, L.L.C.
Sean K. Branham D.C.
7411 Manchester Rd.
St. Louis, MO 63143
(314) 647-1384
fax (314) 781-1374

Policies & Information

Welcome to Premier Healthcare LLC. Thank you very much for choosing us to care for you. It is part of our "Extra Caring" approach to health care to openly discuss our office policy with you. We believe that a clear definition of our office policy will allow both you, the patient, and us, the clinic to concentrate on the big issue – REGAINING AND MAINTAINING YOUR HEALTH.

APPOINTMENT POLICY

1. Multiple appointments have been scheduled for your convenience to minimize waiting and to facilitate incorporating these appointments into your daily routine.
2. Regardless of how many appointments are scheduled for you each week please note that it is the frequency of visits that count, not the days.
3. Therefore, if you are unable to keep an appointment for any reason, we require that you call immediately to reschedule your visit. It is your obligation to make up a missed appointment within 7 days of cancellation.
4. This office reserves the right to charge for missed appointments and those cancelled without 24 hours notice. **The cancellation and no show charge will be $25.**
5. When entering the office on any given visit, please go directly to the front desk and sign in. We attempt to honor all appointments at the scheduled time. If you are late, you may have to wait for the next available appointment. If you have any questions regarding your appointments, please do not hesitate to speak to the doctor directly.

FINANCIAL POLICY

1. It is our policy that all services rendered in this office are charged directly to you, the patient and that you are personally responsible for all payments regardless of whether or not this office accepts insurance assignments.
2. All payments are expected at the time of service or at the end of each week. Payment can be made in the form of cash, personal check or credit card. There is a $25 charge on all returned checks.
3. All insurance assignment patients must pay their deductable in full and the co-insurance at the time of service or at the end of each week.
4. For all patients with non-participating health insurance the first visit will be charged on a cash basis.
5. I understand that if I suspend or terminate my care and end treatment, any fee for professional services rendered to me will be immediately due and payable. If it is necessary to send unpaid fees to collections, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 25% of the debt, and all costs and expenses, including reasonably attorneys' fees, we incur in such collection efforts. Those outstanding charges will be charged at an interest rate of 1.5% monthly.
6. Most insurance companies will pay for the usual and customary charges of this office; however, this office will not enter into any dispute with an insurance company over the amount of reimbursement.

Thank you for understanding our office policy. Please let us know if you have any questions or concerns.

I have read, understand and agree to the above policies.

Patient Name:_____

Patient Signature:_____ Date:_____

PATIENT FINANCIAL RESPONSIBILITIES & CONSENT REQUESTS

CONSENT TO EXAMINE & TREAT

I authorize the performance of an examination which Dr. Branham or his associates may consider necessary or advisable in the course of establishing a differential diagnosis. I also authorize the performance of any and all physiological therapeutics as well as manipulative therapy which may be necessary or advisable in the course of treatment by Dr. Branham and his associates.
Patient Initials _____ Dr. Initials _____

CONSENT TO EXAMINE & TREAT CHILD

I authorize the performance of an examination of my child which Dr. Branham or his associates may consider necessary or advisable in the course of establishing a differential diagnosis. I also authorize the performance of any and all physiological therapeutics as well as manipulative therapy which may be necessary or advisable in the course of treatment by Dr. Branham and his associates to my child.
Patient Initials _____ Dr. Initials _____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS & CARE

If any tests were performed outside of this office (laboratory or other diagnostic procedures) I understand that the doctor will notify me of the results within an acceptable time frame not to exceed 1 week from my last appointment.
Patient Initials _____ Dr. Initials _____

I have had an opportunity to discuss with Dr. Branham the nature and purpose of chiropractic adjustments and other procedures. I understand the results are not guaranteed.
Patient Initials _____ Dr. Initials _____

I further understand and am informed that as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, and strokes. I do not expect the doctor to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then unknown, is in my best interests.
Patient Initials _____ Dr. Initials _____

AUTHORIZATION FOR MAJOR MEDICAL INSURANCE PAYMENT

I authorize the release of any medical or other information necessary to process any and all insurance claims from Dr. Branham's office. I authorize payment directly to Dr. Sean Branham, DC for services rendered.
Patient Initials _____ Dr. Initials _____

AUTHORIZATION FOR MEDICAL PAYMENTS FROM MY AUTOMOBILE INSURANCE

I authorize and instruct my automobile insurance carrier to send (mail) all paid monies for diagnostic testing, treatment, and/or medical supplies to Dr. Sean Branham, DC for all services/supplies billed. A photocopy of this authorization shall be considered as valid as the original. I authorize direct payment to Dr. Sean Branham, DC. In addition, I hereby give limited Power of Attorney for Dr. Sean Branham, DC to cash and deposit any sums paid by my insurance carrier for only the specific injury indicated on billing statement. I authorize Dr. Sean Branham to release any information pertinent to my case with my automobile insurance carrier. I authorize Dr. Sean Branham to use my name in the "Signature on File" in future billings. I authorize use of this form on all of my insurance submissions (billings).
Patient Initials _____ Dr. Initials _____

Note: Read & sign Assignment of Benefits form.

PAYMENT RESPONSIBILITY

Payment is due when services are rendered for all costs not covered by a third party carrier. Balances including auto and work injury claims must be paid in full within 90 days of treatment unless otherwise noted. Service charge of 1.5% per month are added to all balances outstanding 60+ days and are the responsibility of the patient unless otherwise noted by Dr. Branham. By my initials, I agree to be held responsible to treatment rendered and I further agree to pay a 25% collection charge, in the event of default, if the account is placed with an attorney or bonded collection agency.

Patient Initials _____ Dr. Initials _____

Patient co-pays are due at each visit and can be paid in advance of scheduled appointments. I fully understand that deductibles and co-pay amounts are my responsibility. I also understand that deductibles can be paid in a three month flexible payment plan which is determined by the doctor and office personnel.

Patient Initials _____ Dr. Initials _____

Hardship Exemptions: Insurance regulations do not allow doctors to waive either deductibles or co-payments. If you feel you cannot afford to pay deductibles or co-payments, a hardship exemption may be granted by the Doctor.

SERVICES NOT COVERED BY INSURANCE

I understand that I will be financially responsible for any and all services not covered in accordance with the guidelines outlined in my insurance plan documents.

Patient Initials _____ Dr. Initials _____

UNITED HEALTHCARE MEMBERS ONLY

I understand that United Healthcare will only cover manipulative therapy in Dr. Branham's office. Therefore, any other therapies/supplies that are recommended will be my responsibility.

Patient Initials _____ Dr. Initials _____

NUTRITIONAL SUPPLEMENTS/SUPPLIES

I understand that any and all prescribed nutritional supplements and adjunctive supports such as analgesic creams, back supports, braces, at-home rehabilitative devices must be paid at time of sale. NO EXCEPTIONS. These items are subject to local and state sales taxes.

Patient Initials _____ Dr. Initials _____

ACKNOWLEDGEMENT OF RECOMMENDED ACTION PLAN BY DOCTOR AND STAFF

I acknowledge that Dr. Branham and his staff have reviewed with me my recommended action plan. I furthermore acknowledge that Dr. Branham has discussed with me financial obligations and I agree to begin treatment.

Patient Initials _____ Dr. Initials _____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)