Welcome to Burcon Chiropractic

Last Name _____ First _____Middle ___Nickname _____

Street Address _____ City _____

State _____Zip _____-_____ E-Mail _____ @ _____

Home Phone (_____) _____ - _____ Work Phone (_____) _____ - _____

Cell Phone (_____) _____ - _____ Please circle preferred number

Date of Birth ____ / ____ / _____ Sex: M F Employer _____

Emergency Contact_____ Phone _____

Marital Status: Single Married Divorced Widowed Student Status_____

Race _____ Referred by ___ _____ Today's Date _____

Describe Your Problem(s) _____

_____

_____

When did it Start _____ Was it Due to an Accident _____

Have any X-Rays, C-Scans or MRIs been taken _____

Primary Insurance Company _____ HSA/FSA Account? _____

Please give insurance card(s) and photo ID to have them copied by staff.

Subscriber _____ Relationship _____

Does it Cover Chiropractic Care _____ How Much is Your Deductible $_____

How Much is Your Co-Pay $_____Secondary Insurance Company _____

Subscriber _____ Relationship _____

If Primary or Secondary Subscriber is Someone Other than You, Please List Their:

Name_____ Employer _____ Birth Date ___ /___ / _____

Does anything make Problem Better _____

Does anything make Problem Worse _____

Surgeries _____

Broken Bones _____

Diagnosed Illnesses _____

Secondary Health Problems _____

Old injuries are important to our protocol. It often takes 15 years before symptoms begin:

List All Car Accidents _____

_____

Other Injuries _____

Medications with Dosage _____

_____

Allergies _____ Most recent blood pressure _____/____

Height _____ in Weight _____ lbs. Body Mass Index ____ (If 0ver 25 we recommend

Weight Watchers) Handed: Right Left Ambidextrous; Mattress Type & Age_____

Sleeping Position: Back R Side L Side Stomach; Type of pillow _____

Heel Lifts or Orthotics _____ Major Dental Work _____

What do you do at Work _____

Exercise/Hobbies _____

Describe your Diet _____

Smoking: Never Former Heavy Light How much water do you drink daily _____

Any Problems with your Birth _____

(Mothers Only) Children's Ages _____ Any Birth Problems _____

BURCON CHIROPRACTIC

Informed Consent, Terms of Acceptance & Notice of Privacy Matters

1. We will submit some insurance claims as a courtesy. You are responsible for the balance. Payment is due at time of service.
2. Accounts over 30 days past due will be charged late fee of $40.00. Additional months @ 1% interest. Sent to collections after 60 days.
3. MEDICARE: Most Medicare plans do not cover the new patient visit or x-rays.
4. AUTO CLAIMS: We do not bill auto insurance. We will provide you with a superbill that you can submit. If you have full benefits send it directly to them. If you have coordinated benefits, you must send it to your health insurance first, then send their EOB to the auto company.
5. OUT OF STATE CLAIMS: We only BCBS. All other must be paid in advance. We will send BCBS a super bill for your convenience. You will have to send in all others.
6. Meniere's One Week Intensive Care Program average cost $3,000.00. Some procedures, like rest and rechecks or thermography, will not be covered by insurance companies. BCBS insurance may cover up to $500.00 to $600.00, minus copays and deductibles.
7. We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of your spinal examination, we encounter a non-chiropractic or unusual finding, we will recommend that you seek the services of a health care provider in that area.
8. The privacy of your medical information is important to us. The law requires us to keep your information private, and to give you this notice. If at any time you require a copy of your chart, a signed RELEASE OF RECORDS will be required from you before we release any of your information.
9. If you choose to use your insurance, we will share your information with them.
10. We may share your medical information with other doctors and health care workers that are taking care of you. As a Research Institute, we may use your statistical data in a research paper, but not your name.
11. We must disclose your information to the authorities if you are the possible victim of abuse.
12. You have the right to a list of everyone that has access to your file.
13. If you think that we have violated your privacy, please let us know in writing.
14. You may report any HIPAA violation to the Michigan Department of Health.
15. If you have any questions, contact practice administrator, Michael T. Burcon, B.Ph., DC.
16. There is a missed appointment fee of $40.00; four hours minimum cancellation notification.
17. Returned check fee is $40.00.
18. We need annual x-rays on file before we make adjustments. You may borrow your films for 30 days.
19. We may send you information via e-mail or cell phone.
20. You must rest for 15 minutes after a cervical adjustment.

_____ _____ _____

Patient Signature Printed Name Date

_____

Parent or Guardian's Signature