Benjamin Chiropractic & Functional Nutrition Center, P.C.

The office of Rosemary A. Benjamin, BS, DC
114 S. 2ND ST., POB 289, FOWLERVILLE, MI 48836 *** PH./FAX: 517-223-9900
EMAIL: DRROSE@BENJAMINCHIROPRACTIC.COM WEBSITE: WWW.BENJAMINCHIROPRACTIC.COM

Patient History

Name_____ Date_____

Address_____City _____ State_____ Zip_____

H. Phone _____ Cell Phone_____

Email _____ Date of Birth_____ Age_____

Social Security Number: _____ Referred by_____

Occupation_____ Work Phone: _____

Employer Name Address:_____

_____

Marital Status (circle) S M D W Spouse / Partners Name_____

Spouses Occupation_____

Number of Children/Ages_____ Have you ever received Chiropractic Care? Yes / No

What is your blood type? O+ / O- / A+ / A- / B+ / B- / AB+ / AB-

Please circle for each of the following:		Patient Comment If answer is Yes	Chiropractor's Comments
1. Regarding YOUR Birth Process:			
Was the delivery long/difficult?	Y N	_____	_____
Forceps or extraction used?	Y N	_____	_____
Cesarean/ C-Section?	Y N	_____	_____
Breach/ cephalic?	Y N	_____	_____
Home birth?	Y N	_____	_____
Hospital birth?	Y N	_____	_____
Mother given drugs during delivery?	Y N	_____	_____
Was labor induced?	Y N	_____	_____
2. YOUR Growth and Development/ Childhood:			
Were you breast fed?	Y N	_____	_____
Health education?	Y N	_____	_____
Childhood illnesses?	Y N	_____	_____
Ear infections/ Colic/ Asthma?	Y N	_____	_____
Attention Deficit?	Y N	_____	_____
Antibiotics?	Y N	_____	_____
Drugs, prescription, OTC, recreational?	Y N	_____	_____
Surgery?	Y N	_____	_____
Hospitalizations?	Y N	_____	_____
Sports or other physical activities	Y N	_____	_____
Injuries during sports?	Y N	_____	_____
Auto accidents?	Y N	_____	_____
Did you have other traumas?	Y N	_____	_____
Did you ever break any bones?	Y N	_____	_____

3. <u>YOUR</u> Current Health Habits:

Did/do you smoke?	Y N	_____	_____
Did/do you drink alcohol?	Y N	_____	_____
Diet, do you eat healthy foods?	Y N	_____	_____
Have you been in accidents/trauma?	Y N	_____	_____
Have you had surgery?	Y N	_____	_____
Drugs, prescription, OTC, recreational?	Y N	_____	_____
Dental problems?	Y N	_____	_____
Eye problems?	Y N	_____	_____
Hearing problems?	Y N	_____	_____
Exercise regularly?	Y N	_____	_____
Did/do you have occupational stress?	Y N	_____	_____
Drive? Daily time spent driving	Y N	_____	_____
Physical stress?	Y N	_____	_____
Emotional/Mental stress?	Y N	_____	_____
Hobbies/Sports injuries?	Y N	_____	_____
Do you sleep well, hours of sleep?	Y N	_____	_____
Sleeping posture? O side O stomach O back		_____	_____

Symptoms and Present State of Health

Present Complaint/Reason for Seeking Care in this Office:

Major_____

Pain or Problem started on_____

Pains are: O Sharp O Dull/ Ache O Constant O Intermittent O Other_____

Does this pain shoot, radiate, or travel in your body? Where?_____

Are you experiencing numbness or tingling in any area of your body? Where?_____

Since it began, is it: O Same O Better O Worst

What activities aggravate your condition/pain?_____

What activities lessen your condition/pain?_____

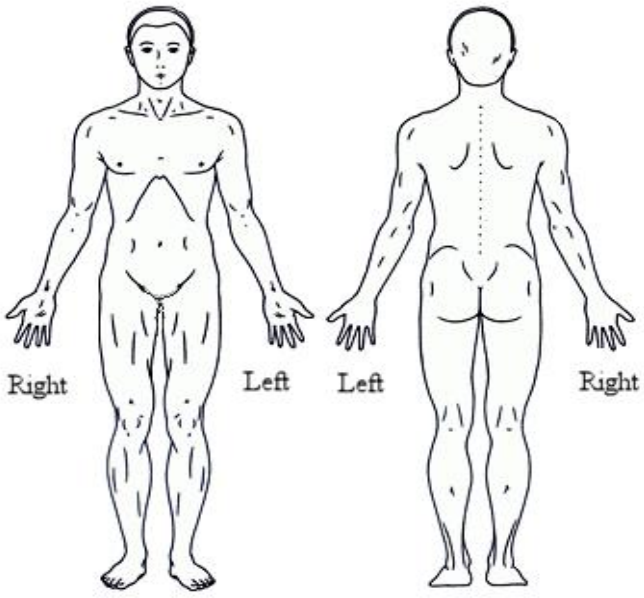
Is this condition worse during certain times of the day?_____

Is this condition interfering with Work?_____ Sleep?_____Routine?_____Other?_____

Is this condition progressively getting worse?_____

Other Doctors seen for this condition_____

Any home remedies? _____



Pain Scale - Please Circle where you are at:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

Using the symbols below; mark the pictures where you feel pain.

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _____	^ ^ ^

Please mark any of the following conditions or symptoms that you have now or have experienced:
Other Symptoms:

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure
O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Fatigue	O Cancer
O Tension	O Depression	O Painful Urination
O Irritability	O Lights Bother Eyes	O Diabetes
O Dizziness	O Loss of Memory	O Diarrhea
O Pain between Shoulders	O Shoulder Pain	O Constipation
O Neck Stiff	O Sinus	O Stomach Upset
O Joint Swelling	O Shortness of Breath	O Heartburn/Reflux
O Fever	O Asthma	O Weight Loss
O Loss of Balance	O Allergies	O Loss of Smell or Taste
O Ringing in Ears	O Cold Hands	O Menstrual Cramps
O Jaw/TMJ Problems	O Cold Feet	O Menopause

Are you under medical care for any condition?

_____

_____

_____

What Medications are you taking?

_____

_____

_____

How long?_____ Have you had surgery?_____ What & When?_____

_____

_____

What side effects have you experienced from the drugs and surgery?

_____

_____

Females Only – Date last Menstrual Period began on_____ Are you possibly pregnant? YES NO

Is there a family History of:

	Heart Disease	Arthritis		Cancer	Diabetes	Other_____
Father's side	O	O	O	O	O	
Mother's side	O	O	O	O	O	

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

I agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that I am personally responsible for payment of any and all services rendered to me. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patient Signature _____ Date _____

Parent or Legal Guardian _____ Date _____

OFFICE POLICIES:

Please note that professional services are rendered and charged to the patient and not to the insurance company.

- Any co-pays and/or co-insurance amounts and/or deductibles are due at the time that services are rendered.
- If your plan requires a referral, you are responsible for getting a referral from your Primary Care Physician prior to your first visit in our office.
- You are responsible for verifying coverage with your insurance company on the sheet provided or via your insurance company website and emailing the attachments to our office at BenjaminChiroPC@gmail.com.
- Information provided by this office does not determine actual benefits payable by your insurance company. Your insurance company determines actual benefits for provided services when claims are submitted.
- You are responsible for any services provided that are not covered by insurance.
- This office cannot accept responsibility for collecting your insurance claim/claims or for negotiating a settlement on any disputed claim/claims that our office has submitted for services rendered on your behalf. Please be aware that insurance covers care for acute conditions only.

FOR ALL PATIENTS WITH INSURANCE:

Authorization for assignment of benefits and information release; I, the undersigned, authorize direct payment of healthcare benefits to Benjamin Chiropractic & Functional Nutrition Center, P.C. (BCFNC) for any healthcare service furnished to me. I understand that I am financially responsible for any amount not covered by my insurance company. I authorize BCFNC to release to my insurance company information concerning healthcare, advice, treatment, or supplies, provided to me. I agree that BCFNC reserves the right to charge 1.5% interest per month on my unpaid balances. I authorize my insurance company and other healthcare providers to release information concerning healthcare, advice, treatment, or supplies provided to me to by BCFNC.

Patient Signature: _____ Date: _____

FINANCIAL, CANCELLATION AND RESCHEDULING POLICY:

I authorize Benjamin Chiropractic & Functional Nutrition Center, P.C. and Dr. Rosemary Benjamin to process my insurance, cash, and electronic-Credit/Debit Card or E-check payments for the Chiropractic, Massage, Brain Balancing and Functional Medicine services provided to me. I understand payment is due in full at the time the services are rendered, unless special payment arrangements have been made ahead of time. I understand that there will be a $30.00 returned check fee for any returned checks. I understand that I will be responsible for a $25.00 fee for failure to keep any scheduled appointment without 24 hours prior notification. **All cancellations and appointment changes must be made via phone only at 517-223-9900, not via text or email.**

I have read the above polices and I accept the terms outlined. I understand and accept my financial responsibility to Benjamin Chiropractic & Functional Nutrition Center, P.C.

Patient Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES:
Health Insurance Portability and Accountability Act (HIPAA)
Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Printed Name of Patient *Date*

_____

Signature of Patient or Legal Guardian

PATIENT INSURANCE & VERIFICATION FORM

Name: _____
First M.I. Last

Birth Date: _____ Social Security: _____

Home Address: _____
Street City State Zip Code

Home #: _____ Work #: _____

Cell #: _____ E-mail: _____

Preferred Contact method: Home call / Cell call / Email / Text Cell

Who is your Medical Physician? _____ May we send a report? _____

Doctor: _____

Who is authorized to discuss your account (other than yourself):

1. _____ 2. _____

Emergency Contact and Phone #_____

_____
Physician's Name Address Phone Number

PRIMARY INSURANCE

Insurance Co. _____
Insurance Name Claim Address

Policy #: _____ Group #: _____Referral Needed: Y / N

Name of Policyholder: _____ Date of Birth: _____

Employer: _____
Name of Business Mailing Address Phone Number

SECONDARY INSURANCE

Insurance Co. _____
Insurance Name Claim Address

Policy #: _____ Group #: _____Referral Needed: Y / N

Name of Policyholder: _____ Date of Birth: _____

Employer: _____
Name of Business Mailing Address Phone Number

Credit Card on File – Policy & Authorization Form

Benjamin Chiropractic & Functional Nutrition Center P.C. (BCFNC) requires a credit/debit card to be on file. Our electronic credit/debit card transaction company is TransEngen. TransEngen stores the information on a separate, secure site. This enables us to run credit card transactions within our system. Office personnel will not have access to your card. Only the last 4 digits of your card will show in our system. TransEngen is certified as a Level One Service Provider with the Payment Card Industry (PCI), Data Security Standard, as well as the VISA Cardholder Information Security Program (CISP). They are audited and scanned for PCI compliance and is regularly scanned for vulnerabilities by ScanAlerT and is a member of their HACKER SAFE program.

Credit Cards on File will be used for:

Copays Deductibles Co-Insurance Missed Appointment Fee Outstanding Balances Your card will be billed at the time your insurance Explanation of Benefits (EOB) is processed in our office. For patient balances less than $75 your card will automatically billed. Note: BCFNC does not send paper statements for outstanding balances. If your account has an outstanding balance of more than $75 we will attempt to call you 3 times via your personal contact information provided on your initial visit. After the 3rd attempt we will utilize the credit card on file an email the receipt to the responsible party.

For all patient responsibility amounts assigned by insurance, our office reviews these amounts to ensure your claim has been properly adjudicated. If what is adjudicated by the insurance company does not match your benefits we verified with insurance at the time of service, we will contact you and your insurance carrier. Members typically receive their explanation of benefits (EOB) prior to the provider. **If you disagree with the patient responsibility amount owed, it is your responsibility to contact your insurance carrier immediately.**

During the time you leave a credit/debit card on file, if it expires or otherwise becomes uncollectable, we will expect you to promptly provide a new means of payment.

Credits on your account after your insurance claim has been adjusted will be returned to the credit card on file.

We attempt to verify your benefits prior to your appointment to make sure we collect the appropriate amount owed and to make sure your visit will be covered by your insurance plan. However **it remains the policy holder's responsibility to know their insurance policies. BCFNC cannot know all the details of every plan. Ultimately, you are responsible for knowing what services are covered, how often, and how much of the cost is your responsibility. You will be responsible for any portion of services that your insurance does not cover.**

Credit Card on File Authorization

I agree to place my credit card on file with BCFNC. I authorize BCFNC to use my credit/debit card for purposes stated above.

Signature: _____ Date: _____

Patient Print Name: _____

Name as it appears on card (print please) _____

Type of Credit Card (circle two): MasterCard Visa Discover American Express Credit Debit

Card Number: _____ Billing address Zip Code: _____

Expiration Date: _____ CVV Code: _____ (3 digits back of card / AM EX 4 digits front of card)

BCFNC Staff: _____ Date of card swiped: _____

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