

Berard Family Chiropractic

Dr. Christopher J. Berard

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NAME: _____ DATE: _____

HOW DID YOU HEAR ABOUT US? _____

AGE: _____ DATE OF BIRTH: _____ HOBBIES: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

WORK #: _____ HOME #: _____ CELL #: _____

E-MAIL ADDRESS _____

SOCIAL SECURITY #: _____ --- --- --- OCCUPATION: _____

DRIVER'S LICENSE #: _____ STATE: _____ EXP: _____

EMPLOYER: _____ MARITAL STATUS: S M D W

SPOUSE'S NAME: _____ # OF CHILDREN: _____ # OF GRANDCHILDREN: _____

CHILDREN'S NAMES AND AGES: _____

IN CASE OF EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE: _____

HEALTH INSURANCE COMPANY: _____ PHONE #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

POLICY HOLDER: _____ POLICY #: _____

POLICY HOLDER'S SS# _____ --- --- --- DOB: ____ / ____ / ____ PHONE #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PURPOSE OF THIS APPOINTMENT: _____

HAVE YOU BEEN UNDER PREVIOUS CHIROPRACTIC CARE? No Yes DESCRIBE PREVIOUS CHIROPRACTIC EXPERIENCE: _____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? No Yes IF YES, WHAT MEDICATIONS? _____

HAVE YOU HAD ANY TYPE OF SURGERY? No Yes IF YES, WHAT TYPE OF SURGERY AND WHEN? _____

COFFEE/SODA INTAKE? No Yes FREQUENCY: _____ TOBACCO USE? No Yes FREQUENCY _____

- headaches chest pain constipation sleeping problems neck pain back pain stiff neck dizziness often catching colds buzzing in ears tingling in toes/fingers fainting nervousness numbness in toes/fingers ears ringing
- fever tension irritability fatigue cold sweats diarrhea loss of balance jaw pain excess stress poor diet
- poor sleep depression job puts strain on back, neck, and/or feet lack of daily exercise No stretching routine Other: _____



ALL PATIENTS NEED TO CHECK AND READ ALL THAT APPLY:

_____ **PAYMENTS:** Payments are due at the time of each visit. We accept cash, checks, Visa, MasterCard, and Discover.

_____ **PAST DUE ACCOUNTS:** Payments over 30 days due are subject to 3% interest and a \$2.00 statement fee per each monthly statement thereafter until balance is paid.

_____ **GENERAL INSURANCE:** Patients are responsible for payment at the time of each visit. Patients are responsible for deductibles, co-payments, non-covered services, and referrals, if required. Non-contracted services will not be submitted to insurance companies and are the sole responsibility of the patient. Billing insurance is a convenience that we offer our patients. Most insurance companies pay in a timely manner in less than 60 days. However, an insurance company can sometimes take 90 day or even longer to pay.

I, _____ authorize Berard Family Chiropractic Office to charge my credit card or

checking account (check one) for any unpaid fees not paid by the insurance within 60 days. Should my credit card be

billed for unpaid fees, I will be reimbursed or given a credit when the insurance check does arrive.

Patient's or Guardian's Signature: _____ Date: _____

MasterCard Visa Discover Account # _____ Exp: _____

Checking Account # _____ Routing # _____

_____ **I hereby authorize & direct:** the insurance carrier to pay all benefits, which may be due to me according to the policy, directly to Dr. Christopher Berard of Berard Family Chiropractic Office to be applied towards my account.

_____ **BLUE CROSS/BLUE SHIELD OF MASS:** The doctor in this office is a participating Blue Cross/Blue Shield provider. When verification has been completed, we will accept assignment as specified by Blue Cross/Blue Shield for your particular plan. Patients are responsible for all deductibles, co-payments, and non-covered services. I understand that any service the doctor is not contracted for will be paid by me. Non-covered services will not be submitted to Blue Cross/Blue Shield.

_____ **MEDICARE:** The doctor in this office is a participating Medicare provider. Medicare recipients must present their enrollment cards at the onset of treatment. Medicare requires a \$124 annual deductible to be paid before services are covered. In compliance with the Federal MAAC regulations, the fee for spinal manipulation has been set at \$40. Spinal Manipulation is the only service covered by Medicare. If the patient does not have a second insurance or the second insurance does not cover the treatment, the patient will be required to pay a co-payment. Patients are responsible for any non-covered services.

_____ **CANCELLATIONS:** If you are unable to keep an appointment, we ask that you kindly provide us with at least 24 hours notice. We ask for this advance notice so that we can offer this appointment to another patient. There is a \$10 fee charged if a patient does not show up for an appointment without sufficient notice.

_____ **RETURNED CHECKS:** There is a \$10 charge for: returned/bounced checks as well as no-shows.

_____ **I understand and agree:** that all fees for professional services rendered in my behalf are my personal responsibility and are due and payable at the time of services rendered. I understand that any fees not paid by the insurance company will be paid directly by me upon notification. I hereby authorize and direct Dr. Christopher Berard of Berard Family Chiropractic Office to release all medical information necessary to process this claim.

_____ I received the **HIPAA Notice**

_____ I understand that in an event of an emergency, I should call 911.

Patient's or Guardian's Signature: _____ Date: _____

FAMILY HEALTH HISTORY

Is there a history of the following conditions in your family:

- Hypertension Cancer Diabetes Heart Disease Carpal Tunnel Problems ADD/ADHD Sleep disorders Depression
- Obesity Ear infections Allergies Autism Irritable Bowel Syndrome Restless Legs Sciatica problems Bed Wetting
- Infertility Fibromyalgia Asthma Arthritis Multiple Sclerosis Chronic Fatigue Anxiety Chronic colds

ALL PATIENTS NEED TO CHECK AND READ ALL THAT APPLY:

ARE YOU HERE TODAY FOR A WORK RELATED ACCIDENT? Yes _____ No: _____

Date of accident: _____ / _____ / _____ **Claim #:** _____

Have you missed any work due to this accident? Yes _____ No: _____

Dates missed: _____

Workman's Compensation Information:

Name of Employer _____ Phone #: _____

Address of employer: _____

City: _____ State _____ Zip: _____

Employers Workman's Compensation Insurance Company:

Name of WC insurance company: _____ Phone #: _____

Address of WC insurance company: _____

City: _____ State _____ Zip: _____

ARE YOU HERE FOR A CLAIM ON A PERSONAL INJURY ACCIDENT? Yes _____ No: _____

Date of accident: _____ / _____ / _____ **Claim #:** _____

Have you missed any work due to this accident? Yes _____ No: _____

Dates missed: _____

Was an accident report filled out? Yes _____ No: _____ **(We'll need a copy)**

Attorney Name: _____ Phone #: _____

Address of attorney's office: _____

City: _____ State _____ Zip: _____

ARE YOU HERE TODAY DUE TO A CAR ACCIDENT? Yes _____ No: _____

Date of accident: _____ / _____ / _____ **Claim #:** _____

Have you missed any work due to this accident? Yes _____ No: _____

Dates missed: _____

Name of the policyholder of the vehicle you were in: _____

Auto Ins. Company Name: _____ Phone #: _____

Address of ins. Co.: _____

City: _____ State _____ Zip: _____

Adjustor name: _____ Phone: _____ Ext. _____

If you have an attorney for this case, please give:

Attorney Name: _____ Phone: _____

Address of attorney's office: _____

City: _____ State _____ Zip: _____

WORKERS COMPENSATION: Patients must report injury w/in 3-5 days after injury. When the proper forms are filed, we will accept the assignment as a work related case. If the patient's injury is found not to be work-related & is denied by the insurance company and the Industrial Accident Board, the patient will be responsible for payment of his or her bill either through their medical insurance carrier or themselves.

AUTO ACCIDENT: Patients are required to complete a Personal Injury Protection Form (PIP). When the proper forms are filed, we will accept the assignment for medical costs covered by your insurance. If an attorney is involved, you must sign a lien which we will mail your attorney.

PATIENTS ARE RESPONSIBLE FOR ANY NON-COVERED SERVICES.

Patient Signature: _____ **Date:** _____ / _____ / _____

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both parties to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

HEALTH: A state of optimal physical, mental, and social wellbeing, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings we will recommend that you seek the services of another health care provider. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

OUR ONLY PRACTICE OBJECTIVE IS TO ELIMINATE A MAJOR INTERFERENCE TO THE EXPRESSION OF THE BODY'S INNATE WISDOM.

Our only method is specific to adjusting to correct vertebral subluxations.

SAFETY: The data regarding the safety of any health care profession is reflected in the malpractice insurance premiums the profession pays. This data is void of passion or prejudice. It merely reflects the cost in dollars for the suffering caused by a particular health care profession. Medical internists are considered to have some of the lowest medical malpractice rates. Even so, they can pay more than \$30,000 each year in states in where there is no "cap" on the awards juries can give patients. Obstetricians in Florida pay almost \$280,000 per year. Due to chiropractic's high level of safety, Doctors of Chiropractic pay, on average, approximately \$2,000 per year for malpractice insurance. Statistics demonstrate that patient risk is substantially lower in chiropractic as opposed to medical care, where the use of prescription drugs and surgery pose far greater risk.

- Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care. While it is not generally dangerous, please advise your Doctor of Chiropractic if you experience soreness or discomfort.
- On rare occasion, chiropractic treatment may aggravate a disc injury or cause other minor joint, ligament, tendon, or other soft tissue injury.
- Manual adjustments to the thoracic spine, in very uncommon cases, may cause rib or other bone injury or fracture. Treatment is performed carefully to minimize such risk.
- Cervical adjustments pose an uncommon risk of stroke because the vertebral arteries supply the brain with blood and are located within the bones of the cervical spine. The Journal of CCA estimates that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments.

I, _____ (print name) have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____ (signature) _____ (date)

Consent to evaluate and adjust a minor child: I _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care. Parent social security number: _____