

PATIENT CONFIDENTIALITY PERSONAL DATA

No. _____ Date _____
Patient: _____ Date of Birth: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Social Security No.: _____ Home Phone: _____ Mobile: _____
Work Phone: _____ Email: _____
Employer: _____ Address: _____
Name of Spouse: _____ SS No.: _____ No. of Children: _____
Spouse's Employer: _____ Address: _____
How did you learn of this clinic? _____
Nearest relative not living with you? _____ Phone: _____
Who is responsible for payment? Self Spouse Other _____
PATIENT'S INSURANCE SPOUSE'S INSURANCE
Name of Company: _____ Name of Company: _____
Address: _____ Address: _____
ID & Group No.: _____ ID & Group No.: _____
Phone No.: _____ Phone No.: _____
Purpose of this appointment and list your complaints: _____

Date of illness: _____ Time: _____ AM PM Location: _____
How did accident occur? Auto On the job Other, _____
Please describe the circumstances and what makes the condition(s) better or worse: _____

Other Doctor seen for this condition: _____
Have you been treated by a Doctor for any health condition in the last year? Yes No
If yes, please describe: _____

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement 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 on 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.

Signature Physician: _____ Signature Patient: _____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize the doctor and whomever he may designate as his assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in any case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

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

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Your Protected Health Information will be used by this office or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the privacy practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information. It is the policy of this office to continue to provide treatment for a patient who restricts consent to the use and disclosure of his or her Protected Health Information for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I, _____ (print) acknowledge that I have reviewed the above information and give my permission to this office to use and disclose my health information in accordance with it.

I, _____ (print) acknowledge that I have reviewed the above information and **DO NOT** give my permission to release any information to my insurance carrier. I do understand that PHI will be used within the office for purposes of my care to those individuals designated by the doctor.

ASSIGNMENT OF BENEFITS

At the beginning of your treatment, our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payment of services provided. Should your insurance provide Chiropractic benefits, your insurance will be filed on a weekly basis as a courtesy to you. You will be responsible for your deductible and/or co-payment. Your insurance should pay within 45 days from the date in which it was filed. By taking your insurance on assignment, our office agrees to wait for a portion of your bill for an estimated amount of time. In the event that your insurance company does not pay on a timely basis, you may be asked to contact your insurance carrier. **If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.**

Assignment and Conveyance of Lien Interest

I hereby execute and provide **Irrevocable Lien Interest and Assignment of Proceeds** to apply to all monetary proceeds from any third party liability insurance policy and/or all monetary proceeds from any PIP/medical payment insurance policy to which I am entitled, and from which I am to be paid in the form of an insurance settlement(s), claim(s), judgment(s), or verdict(s) resulting from any identified accident. The Insurance Carrier is instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds the total dollar amount of all sums which I owe on account to the above named doctor and treating facility, as evidenced by the medical bills submitted by the doctor and/or treating facility, shall be paid directly to the above named doctor and treating facility by the insurance carrier out of those settlement proceeds to which I am entitled, or withheld from any settlement or award to which I shall be entitled and thereafter be paid directly to the above named doctor and/or treating facility. In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account to such named doctor and treating facility and remit payment of all such sums directly to such named doctor and/or treating facility upon receipt of my settlement award(s).

INFORMED CONSENT TO TREATMENT

I hereby authorize and release the doctor and any individual he/she may designate as his/her assistant to administer treatment, physical examination, x-ray studies, chiropractic care, or any clinical services that he/she deems necessary in my case. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as "rare" and the probability of adverse reaction due to ancillary procedures is also considered "rare."

INFORMED CONSENT FOR INFARED LASER THERAPY

Laser therapy is a safe and effective therapy that is FDA cleared for the temporary relief of pain and reduction of symptoms associated with mild arthritis and muscle pain. Laser also promotes relaxation of muscle spasms and promotes vasodilation. Adverse effects from laser therapy are normally rare and temporary.

Pain relief from laser therapy may be dramatic and substantial, lasting for hours, days or weeks. However, your results may be minimal or insignificant. Adverse effects of laser therapy may occur from multiple causes including hypersensitivity, pre-existing health conditions, thermal effects, excessive pressure from the probe, and laser over-stimulation. Laser light can damage the retina in your eye. Always wear the laser protective glasses provided. The most common adverse effects are:

1. Temporary increase in pain during application of laser.
2. Temporary increase in pain the following day after laser therapy.
3. Mild bruising from vasodilation or direct pressure of laser tip.
4. Temporary dizziness.
5. Reactions when photosensitizing drugs are used with laser therapy.

I understand the risks of laser therapy and agree to the treatment program outlined by my doctor.

Patient Signature: _____

Date: _____

PATIENT INTRODUCTION CARD

NO. _____

DATE: _____

PATIENT'S NAME: _____ PHONE: _____

STREET ADDRESS: _____ AGE: _____ DATE OF BIRTH: _____

CITY, ST, ZIP: _____

NAME OF INSURANCE CO.: _____

MAJOR COMPLAINT: _____

WHO REFERRED YOU? _____

CONSENT TO TREATMENT OF MINOR

I HEREBY AUTHORIZE:

DR. RODNEY D. LANGEL

AND WHOMEVER HE MAY DESIGNATE AS ASSISTANTS TO ADMINISTER
EXAMINATIONS AND CHIROPRACTIC CARE AS DEEMED NECESSARY TO:

MINOR PATIENT'S NAME

SIGNATURE OF PARENT OR GUARDIAN

WITNESS

Patient ID# _____

Patient Summary Form

PGF-760 (Rev. 2/14/2008)

Instructions
Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.
*Fax number may vary by plan.

Patient Information

Patient name: Last First MI			<input type="radio"/> Female	Patient date of birth		
			<input type="radio"/> Male			
Patient address				City	State	Zip code
Patient insurance ID#		Health plan		Group number		
Referring physician (if applicable)		Date referral issued (if applicable)		Referral number (if applicable)		

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form) _____

2. Federal tax ID (EIN) of entity in box #1 _____

3. Name and credentials of the individual performing the service(s) _____

4. Alternate name (if any) of entity in box #1 _____

5. NPI of entity in box #1 _____

6. Phone number _____

7. Address of the billing provider or facility indicated in box #1 _____

8. City _____

9. State _____

10. Zip code _____

Date you want THIS submission to begin: _____

- Patient Type**
- 1 New to your office
 - 2 Est'd, new injury
 - 3 Est'd, new episode
 - 4 Est'd, continuing care

- Cause of Current Episode**
- 1 Traumatic
 - 2 Unspecified
 - 3 Repetitive
 - 4 Post-surgical
 - 5 Work related
 - 6 Motor vehicle

Date of Surgery

_____/_____/_____

Type of Surgery

- 1 ACL Reconstruction
- 2 Rotator Cuff/Labral Repair
- 3 Tendon Repair
- 4 Spinal Fusion
- 5 Joint Replacement
- 6 Other _____

Diagnosis (ICD-9 code)
Please indicate if digits are correct/incorrect

1° _____

2° _____

3° _____

4° _____

- Nature of Condition**
- 1 Initial onset (within last 3 months)
 - 2 Recurrent (multiple episodes of < 3 months)
 - 3 Chronic (continuous duration > 3 months)

DC ONLY

Anticipated CMT Level

98840 98842

98841 98843

Current Functional Measure Score

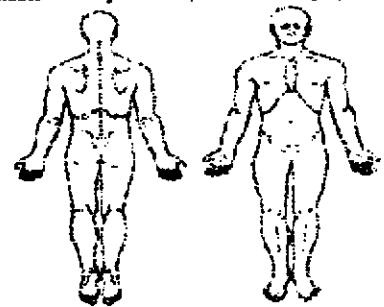
Neck Index _____ DASH _____ (other) _____

Back Index _____ LEFS _____

Symptoms began on: _____

1. Briefly describe your symptoms: _____
2. How did your symptoms start? _____
3. Average pain intensity:
- Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain
- Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain
4. How often do you experience your symptoms?
- 1 Constantly (75%-100% of the time) 2 Frequently (51%-75% of the time) 3 Occasionally (25% - 50% of the time) 4 Intermittently (0%-25% of the time)
5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)
- 1 Not at all 2 A little bit 3 Moderately 4 Quite a bit 5 Extremely
6. How is your condition changing, since care began at this facility?
- 0 N/A — This is the initial visit 1 Much worse 2 Worse 3 A little worse 4 No change 5 A little better 6 Better 7 Much better
7. In general, would you say your overall health right now is...
- 1 Excellent 2 Very good 3 Good 4 Fair 5 Poor

Indicate where you have pain or other symptoms:



Patient Signature: X _____

Date: _____

OptumHealthSM

UnitedHealth Care Insurance

**Patient Billing Acknowledgement Form
Non-Covered Services****

Under your health plan, you are financially responsible for co-payments, co-insurance and deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non-covered services as defined by your health plan contract. For example, this may include items such as supplies, vitamins, or durable medical equipment.

The services or products listed below are not covered according to your health plan. Your acknowledgement below indicates that you have been advised of this information and that you agree to pay for the listed services or products.

**** Not for use in New Jersey**

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Services to be provided:

Supply _____ DME _____

Modalities/Procedures _____ Other _____

Time frame from _____ through _____

Schedule/details _____

Provider Signature: _____

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I _____ acknowledge that I have been told

Patient Name – Printed or Typed

in advance by my provider that the services/products listed above are not covered by my Health Plan. I agree to pay for these non-covered services.

Patient/Guardian Signature

Date

Langel Chiropractic Clinic P.C.
5907 Ashworth Rd.
West Des Moines, IA 50266
Ph. 515-267-1600

UnitedHealth Care Insurance

Patient Billing Acknowledgement Form Maintenance/Elective Care**

Under your health plan, you are financially responsible for co-payments, co-insurance or deductibles for covered services. You are also financially responsible for all non-covered services, including care determined to be elective or maintenance.

Maintenance/Elective care is treatment that does not significantly improve a clinical condition. While being treated for a chronic condition, you may elect to receive care beyond that which is determined to be medically necessary. You may also choose to receive maintenance care once maximum benefit from treatment has been reached.

If, during the course of Maintenance/Elective Care, you develop a new condition or a previous condition becomes significantly worse, care may no longer be considered Maintenance/Elective and may then be covered by your health plan. Your provider must submit a request for insurance coverage.

** Not for use in New Jersey

P R O V I D E R	<p><u>Services to be provided are listed below:</u></p> <p><input type="checkbox"/> Chiropractic Manipulative Therapy _____ <input type="checkbox"/> In-Home Care _____</p> <p><input type="checkbox"/> Modalities/Procedures _____ <input type="checkbox"/> Other _____</p> <p>Time frame from _____ through _____</p> <p>Schedule/details _____</p> <p>Provider Signature: _____</p>
P A T I E N T	<p>I _____, acknowledge that I have been told <small>Patient Name - Printed or Typed</small> in advance by my provider that the services/products listed above are not covered by my Health Plan. I agree to pay for these non-covered services.</p> <p>Patient/Guardian Signature _____ Date _____</p>

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