Bobb Chiropractic Center

813 1st Avenue
Silvis, Illinois 61282
Phone: (309) 755-5203   Fax: (309) 755-5285
Email: Bobbchiropractic@yahoo.com

Patient Financial Responsibility Statement

Proper insurance information and documentation are necessary to process claims through your insurance provider. You are responsible for all costs of care. Cash payment, co-payment, and co-insurance amount are due at the time of your visit. If all necessary insurance information (Health Plan, Auto Accident, Work Compensation, Etc.) is not provided, you are responsible for payment.

It is your responsibility to know and understand your insurance policy such as prior authorization, deductibles, co-payments, and/or co-insurance amounts. If your health plan has lapsed or expired at the time of receipt of services, you are responsible for payment. If you are not familiar with your health plan coverage, it is recommended you contact your carrier or plan provider.

If your insurance carrier does not remit timely payment on your claim, you will be responsible for payment of the charges. Once your insurance carrier processes your claim, you will be billed for the remaining patient balance, a credit will be applied to your account, or Bobb Chiropractic Center will reimburse you or your insurance company for overpayment.

Accounts that have not been paid on within 31 days are considered past due and can be sent to collections.

A $10.00 fee may be applied to your account for "No Show" appointments.

By signing below, you authorize Bobb Chiropractic Center to release all information necessary to secure the payment of benefits through your insurance company and agree to the conditions in this statement.

Patient Printed Name:______________________________________

Patient Signature:____ Date:____________

Office Signature: ____ Date:____________

Bobb Chiropractic

Health Questionnaire

______New Patient ______ Re-Exam

____________ Date of Last Exam

Patient Information

Name:______________________________________Birth Date:______________Age:_____Gender:_____

Preferred Name: ____

Address: ______________________________________City:_______________State:_____ Zip:________

Primary Phone: (_____)__________________ Secondary Phone: (_____)______________________

Email:_______________________________________ Social Security #: ____________________

Occupation: __________________________Employer: _______________________________________

Employer Address: ____ Phone: (_____)_____________

Marital Status: _______________________ Spouse's Name: ___________________________________

Emergency Contact Name:____________________________________Phone: (____)__________________

How were you referred to our office? ____

Insured's Name and Date of Birth (if not patient): __________________________________

Do you accept calls before 8:00am?_____________ Do you accept text messages? ________________

Symptom Information

When did your symptoms begin? ____

What caused your symptoms to occur? (lifting, fall, accident, stress, etc)

____

____

____

Please rate your pain on the scale:

No Discomfort — Worst Discomfort

1 2 3 4 5 6 7 8 9 10

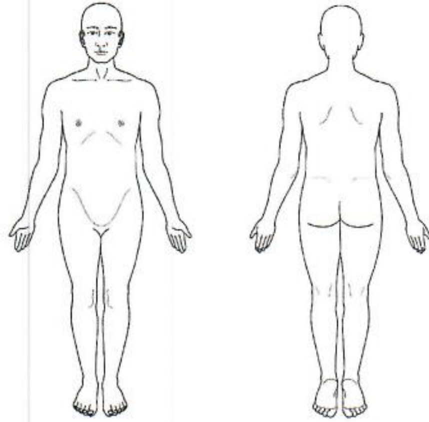
Describe your symptoms (circle all that apply):

Electric Sharp Stabbing Piercing Shooting Achy Heavy Cramp-like

Burning Deep Superficial Stiff Spasm Numb Radiating

Patient Name: ___________________________

Shade in the areas on the diagram where you feel discomfort or symptoms:



Current Medications:____

____

____

____

Height: _________ Weight:________

Office Use Only:	Pulse __________ Blood Pressure __________ FRI Score _____ Oswestry Score_____ Neck Index Score_____

Health History

Previous Chiropractic Treatment: Yes No

When? ____

Areas Treated:____

Previous Surgeries:

Knee Replacement:	Yes	No	Right Left When:_________________
Hip Replacement:	Yes	No	Right Left When:_________________
Spinal Fusion:	Yes	No	Level of Fusion: ______________________
Other Surgeries:	Yes	No	Area/When: ______________________

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Patient Name: ______________________

Bruise easily	Yes	No	______
Sensitive to touch/pressure	Yes	No	______
High/Low blood pressure	Yes	No	______
Stroke	Yes	No	______
Heart Attack	Yes	No	______
Varicose veins	Yes	No	______
Respiratory	Yes	No	______
Cancer	Yes	No	______
Neurological	Yes	No	______
Epilepsy, seizures	Yes	No	______
Headaches, Migraines	Yes	No	______
Dizziness, ringing in the ears	Yes	No	______
Digestive conditions	Yes	No	______
Kidney disease, infection	Yes	No	______
Arthritis rheumatoid/osteoarthritis	Yes	No	______
Osteoporosis/degenerative disease	Yes	No	______
Scoliosis	Yes	No	______
Broken bones	Yes	No	______
Diabetes	Yes	No	______
Endocrine/thyroid conditions	Yes	No	______
Depression, anxiety	Yes	No	______
Memory Loss, confusion	Yes	No	______
Skin Conditions	Yes	No	______

Additional Comments:

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The information on this form is accurate and to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient/Insured Signature:______________________ Date: __________

Printed Name: ______________________

I have read the Privacy Practices and understand my rights contained in this notice.

By way of my signature, I provide Bobb Chiropractic Center with my authorization and consent to use and disclose my protected health information for the purpose of treatment, payment, and health care operations as described in the Privacy Practices.

____
Patient's Printed Name

_______________________________ _______________
Patient's Signature Date

_______________________________ _______________
Office Signature Date

Updated March 2020