Bobb Chiropractic Center

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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 coinsurance 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 within 31 days are considered past due and can be sent to collections.

Int._____ A $15.00 fee will be applied to your account for "No Call,No Show" appointments. If you need to cancel your appointment, we ask that you give us 24 hours notice.

If a check is returned by the bank for any reason there will be a $25.00 returned check fee added to your account.

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 Visit _____/Over 3 years

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? _____

Current Medications:_____

_____

_____

_____

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 12/20/21

Symptom Information

When did your symptoms begin? _____

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

_____

_____

_____

Height: _____ Weight:_____

Please rate your pain on the scale:

No Discomfort Worst Discomfort

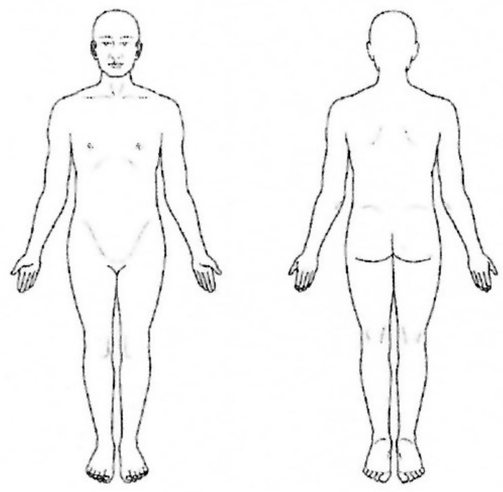
1 2 3 4 5 6 7 8 9 10

Describe your symptoms (circle all that apply):

Electric Sharp Stabbing Piercing Shooting Achy Heavy Cramp-like

Burning Deep Superficial Stiff Spasm Numb Radiating

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



Office Use Only:

Pulse _____

BP _____

FRI _____

Neck _____

Oswestry _____

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: _____		

_____

_____

_____

Date: _____ Patient Name: _____

Patient Signature: _____

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:

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: _____

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Total Score _____

Name _____
PRINTED

_____
Signature

_____
Date