

**LEADING EDGE SPORT & SPINE  
PATIENT INFORMATION**

**Section I: Patient**

Full Legal Name: \_\_\_\_\_ Social Security No.: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_  
Email Address: \_\_\_\_\_  Male  Female  
(for private use only)  Married  Single  Other # of Children: \_\_\_\_  
 Employed  Full-time student  Part-time student  
Employer: \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Occupation: \_\_\_\_\_ Covered by Health Ins.:  Yes  No  
Address: \_\_\_\_\_ Whose:  Self  Spouse  Parent  Medicare  
City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

**Section II: Spouse (if married) or Parent (if minor or student)**

Full Legal Name: \_\_\_\_\_ Social Security No.: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Employer: \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Occupation: \_\_\_\_\_ Covered by Health Ins.:  Yes  No  
Address: \_\_\_\_\_ Whose:  Self  Spouse  Parent  Medicare  
City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Who should we contact (other than spouse) in case of an emergency? \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**How did you hear about us?**

Referral: Who? \_\_\_\_\_  Insurance Plan  Internet  Other: \_\_\_\_\_

⇒ **RELEASE OF INFORMATION** - I hereby authorize Leading Edge Sport & Spine to release information (medical and/or account) to specified insurance companies, attorneys representing my case and healthcare providers necessary for referral or consultation. **Initial:** \_\_\_\_\_

⇒ **AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO PROVIDER** - I hereby irrevocably authorize payment of the medical benefits otherwise payable to me to be made payable and mailed directly to Leading Edge Sport & Spine for professional services rendered. I further agree that in the event insurance benefits exceed the charges of Leading Edge Sport & Spine for services in connection with my treatment, that any such excess amount may first be applied as payment of other indebtedness due Leading Edge Sport & Spine from me or my immediate family on account of other treatment, and the balance, if any remains, refunded appropriately. **Initial:** \_\_\_\_\_

⇒ **RESPONSIBILITY OF BILL** - The undersigned hereby accepts full financial responsibility for charges and services rendered to the patient. The undersigned understands that services are rendered and charged to the patient and not to the insurance company. Leading Edge Sport & Spine cannot accept total responsibility for collecting an insurance claim or negotiating a disputed settlement. The undersigned also agrees that this obligation shall exist regardless of private contractual agreement between the patient and any insurance carrier, attorney, or third party not signing this agreement. **Managed Care Patients**, who have coverage in force, are not responsible for the difference between the usual and customary fees of our office and the negotiated fees of their managed care contract, **for covered services**. All patients, regardless of insurance, are responsible, in full, for non-covered services, which may include: nutritional supplements, supports and supplies, laboratory tests, massage therapy, VAX-D, rehabilitation exercise, and any care not considered "medically necessary". **Initial:** \_\_\_\_\_

⇒ **CONSENT FOR TREATMENT OF MINOR CHILD** - Consent is hereby given by the undersigned for chiropractic treatment and diagnostic studies as ordered by the doctors and performed by the technical staff of Leading Edge Sport & Spine. The undersigned states that he/she is the patient's legal guardian. **Initial:** \_\_\_\_\_

⇒ **NON-PREGNANCY VERIFICATION** - I neither suspect nor know positively at this time that I may be or am pregnant. I release this practice from any and all damages arising from any and all procedures, of a diagnostic or treatment nature with reference to the possibility of pregnancy. **Initial:** \_\_\_\_\_

⇒ **PRIVACY & IMAGING DISCLOSURE** - I understand x-rays, photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand Leading Edge Sport & Spine will retain the ownership rights to these items, but I will be allowed access to view them or obtain copies. I understand these images will be stored in a secure manner that will protect my privacy and comply with HIPAA regulations. Images that identify me will not be released or used outside this office without prior written authorization from me or my legal representative. **Initial:** \_\_\_\_\_

\_\_\_\_\_  
Patient, Agent, or Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

**(OVER)**

# LEADING EDGE SPORT & SPINE

**Medical History for:** \_\_\_\_\_ **Who is your Medical Doctor?** \_\_\_\_\_

**Describe the problems for which you would like our help.**

\_\_\_\_\_

\_\_\_\_\_

**Are your present problems due to an injury?**    No    Yes  
 If yes, what type of injury?    On the job    Auto Accident    Sports    Other \_\_\_\_\_

**Have you made a report of your accident?**    No    Yes  
 If yes, reported to:    Employer    Auto Carrier    Other \_\_\_\_\_

**What other healthcare providers have you seen for these problems?**  
Medical \_\_\_\_\_  
Chiropractic \_\_\_\_\_    Other \_\_\_\_\_

**List all injuries, surgeries, and diseases or medical conditions for which you have sought medical attention in the past.**

Injuries - Dates	Surgeries – Dates	Diseases/Medical Conditions - Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

**List the prescription medications, over-the-counter drugs, vitamins and supplements you take.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Check the symptoms you have experienced in your lifetime.**

- |                                                       |                                                 |                                                     |                                                |
|-------------------------------------------------------|-------------------------------------------------|-----------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Headache                     | <input type="checkbox"/> Scoliosis              | <input type="checkbox"/> Chronic Cough              | <input type="checkbox"/> Erectile dysfunction  |
| <input type="checkbox"/> Fever                        | <input type="checkbox"/> Osteoporosis           | <input type="checkbox"/> Difficulty Breathing       | <input type="checkbox"/> Painful Periods       |
| <input type="checkbox"/> HIV/AIDS                     | <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Menopause             |
| <input type="checkbox"/> Mental disorder              | <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Ulcer                      | <input type="checkbox"/> Hot Flashes           |
| <input type="checkbox"/> Seizures                     | <input type="checkbox"/> Fibromyalgia           | <input type="checkbox"/> Irritable Bowels           | <input type="checkbox"/> Pregnant at this time |
| <input type="checkbox"/> Loss of Sleep                | <input type="checkbox"/> Flat Feet              | <input type="checkbox"/> Abdominal pain             |                                                |
| <input type="checkbox"/> Fatigue                      | <input type="checkbox"/> Arch Pain              | <input type="checkbox"/> Blood in Stool             |                                                |
| <input type="checkbox"/> Cancer/Tumor                 | <input type="checkbox"/> Stroke                 | <input type="checkbox"/> Gall Stones                |                                                |
| <input type="checkbox"/> Loss of Weight (unexplained) | <input type="checkbox"/> Aneurysm               | <input type="checkbox"/> Frequent Urination         |                                                |
| <input type="checkbox"/> Anxiety                      | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Painful Urination          |                                                |
| <input type="checkbox"/> Depression                   | <input type="checkbox"/> Heart Disease          | <input type="checkbox"/> Blood in Urine             |                                                |
| <input type="checkbox"/> Substance Abuse              | <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Inability to Control Urine |                                                |

**Have you been experiencing any of the following symptoms?**

Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty Walking or Balancing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness/Vertigo	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty Speaking or Swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Passing Out	<input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness on one side of body	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nausea/Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**HABITS:**    Smoking - Packs/Day \_\_\_\_\_    Alcohol - Drinks/Day \_\_\_\_\_

**EXERCISE:**    None    Sporadic    Regular    Competitive    Leisure Activities \_\_\_\_\_

**FAMILY HISTORY** - Check conditions that run in your family.

- Cancer    Heart Disease    Stroke    High Blood Pressure    Depression    Headaches  
Arthritis    Diabetes    Back Pain    Scoliosis  
Other \_\_\_\_\_

## Leading Edge Sport & Spine Financial Policies

**IMPORTANT:** Please carefully read each statement below and then initial the plan option that applies to you.

- ✓ **You as the patient are ultimately responsible for your bill**, regardless of the source of payment. Insurance coverage is not a guarantee that all your bills will be paid. Insurance companies vary greatly in what they say they will cover, and what they actually pay. Therefore, we cannot accept whatever insurance pays as payment in full for your care. Managed Care Plans and authorized Worker's Compensation cases are exceptions. We will do our best to provide quality care at reasonable fees.
- ✓ **You are responsible for keeping track** (with our assistance) of any limitations on number of visits or total amount that will be paid.
- ✓ **Your initial visit is to be paid in full today**, unless prior arrangements have been made with our office or your plan allows differently.
- ✓ **All carry-outs (pillows, supports, supplements etc.) are to be paid at the time they are received.** These are not covered by insurance plans.
- ✓ **Your personal balance may not exceed \$200** at any time.
- ✓ **Any services not covered by insurance** will be transferred to your personal balance.

       **Plan #1: FEE FOR SERVICE**      You pay for your visits as you come in on a daily or weekly basis. If you have health insurance and want to file your own claims, we can provide you with a Superbill to send to your Insurance Company. We accept cash, in state checks, Visa, MasterCard, Discover Card, and American Express.

       **Plan #2: HEALTH CARE PLANS**      If you have health insurance with chiropractic benefits, we can file your claims and receive payment from the insurance company. You will be responsible for your first visit, your deductible and/or co-payments as you go along with treatment, plus any amount not covered by insurance. We need the following in order to file your claims.

- Insurance card
- Verification from insurance company that the policy is in force.

Note: If we are going to receive payment from your insurance company, we must go by the information they provide us regarding your deductible, co-payments or limitations.

HMOs and PPOs contract with our practice to provide limited services to patients who have chiropractic benefits available at the time of their visit. Some plans require a referral from your primary care physician; others allow self-referral. *Call your plan before you see the doctor* to make sure you are using your plan correctly. Some HMO plans restrict our office from sending you monthly statements; therefore all co-payments are at the time of your visit. You may choose to pay for several visits at a time, if you will be coming in for a series of treatments. You are responsible to pay in full at the time of service for any non-covered service or supplies that you choose to receive.

       **Plan #3: AUTO ACCIDENTS**      *If you carry Med Pay coverage* on your automobile policy, in most cases, it will pay towards your chiropractic care, regardless of who was at fault. You must report the accident to the police and your insurance carrier; also we must verify that you have Med Pay on your policy. Please provide us with the following.

- Insurance Company name, claim number, name and phone number of the insurance adjuster.
- Copy of the police accident report.

*If you do not carry Med Pay on your auto policy*, or do not have the necessary information, you may use your health insurance or be treated on a fee for service basis. **WE ONLY ACCEPT PATIENTS WHO USE THEIR OWN INSURANCE OR FEE FOR SERVICE.**

       **Plan #4: WORKER'S COMPENSATION**      If you have been injured at work, notify your employer and fill out the "Worker's Compensation Information" form. As soon as we receive approval from your employer and worker's compensation insurance carrier, we will file your claims and receive payment directly from them.

       **Plan #5: MEDICARE**      If you are a Medicare patient, you are responsible for your bill at the time services are rendered. We will file Medicare for you, but you are responsible for filing any supplemental health insurance. Medicare will send you a check for the portion of your visit that they will cover. Please provide us with the following:

- Your Medicare card
- Your driver's license (if applicable)
- Signed Advanced Beneficiary Notice

IF YOU ARE UNSURE OF ANY OF THESE POLICIES, PLEASE ASK THE STAFF BEFORE YOU SEE THE DOCTOR.