Dr. D. Henderson, DC
1630 E. Main - POB 1785 – Warsaw MO 65355

New Patient Appointment Policy

Here at Warsaw Chiropractic, our staff will make every effort to utilize and ensure that we are registered as in-network insurance providers with your insurance.

We are currently in-network providers for several insurance companies, but as you may be aware, policies, coverage and reimbursement for services vary greatly within individual companies/policies.

All new patients, regardless of insurance, will be required to pay the "Initial Visit Fee" of $89.00 on the day of their first visit.

We will make every effort to file this with your insurance. If any of this "Initial Visit Fee" is reimbursed to us from your insurance company, we will reimburse that amount, if any, to you.

This policy limits confusion caused by variations in insurance coverage.

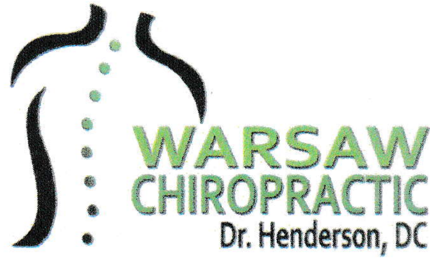
If you have any questions, please direct them to our front desk prior to seeing the doctor.

Please provide your signature and date below stating you have read this policy and your questions have been answered.

Signature: ______________________________

Date: ________________

Thank you and we will be with your shortly!



WELCOME TO WARSAW CHIROPRACTIC

WE MAKE EVERY EFFORT TO KEEP ALL OF YOUR PERSONAL/HEALTH INFORMATION CONFIDENTIAL.
IT WILL NEVER BE SHARED OR SOLD TO ANY PERSON OR BUSINESS WITHOUT YOUR WRITTEN PERMISSION!

PATIENT INFORMATION:

Name____ Date____________

Street Address____

City________________________ State________________ Zip ________________

Home Phone# ____________________ Cell Phone#_________________________

Employer_______________________ Work Phone#________________________

Soc Sec# _____/____/______ E-Mail Address _____________________________

Sex: M____ F ____ Birthdate _____/_____/_____ Age____

Marital Status Single___Married____Widowed____Other__________________

Spouses Name__________________ Emergency Contact ____________________

Who may we thank for referring you to us? _____________________________

INSURANCE INFORMATION:

Who is responsible for account? ____

Please present insurance card(s) to front desk.

Attention: There are some insurance plans that we do not participate with. Even if we do participate with your insurance, there has been a significant increase in different plans within that insurance. It is your responsibility to make sure that we are listed as a provider under your insurance plan.

ACCIDENT INFORMATION:

Is this condition due to an accident? YES___ NO ___ Accident date______________________________

Type Auto ___ Work ___ Home___ Other ____

To whom did you report this accident? Auto Insurance___Employer___

Workers Comp___ Other____

Have you received ANY treatment following this accident? YES____ NO____

Date of Treatment____________________ If yes, what type of treatment?______________________

____

Treatment location _______________________Doctor name____________________________________

PATIENT CONDITION:

MEDICATIONS YOU ARE CURRENTLY TAKING AND WHY:

1.______________________________________ I take for____

2.______________________________________ I take for____

3.______________________________________ I take for ____

4.______________________________________ I take for____

5.______________________________________I take for____

EXERCISE: None _____ Moderate _____ Daily_____ Sports played?____________________________________

WORK HABITS: Sitting___ Standing___ Light labor___ Heavy lifting___ Equipment operator___
Other____

HABITS: Tobacco____packs/day____ Alcohol____drinks/day____ Coffee/soda_____drinks/day______

ARE YOU PREGNANT? YES_____ NO______ STREET/ILLEGAL DRUG USE? YES______ NO______

ON DISABILITY OR IN THE PROCESS OF A MALPRACTICE/INJURY LAWSUIT? YES_____NO______

If yes, please explain____

Last Medical Dr. visit?______________________ Name of Dr.____

Reason for visit?____

Last chiropractic visit? ______________________ Name of Dr.____

Reason for visit? ____

WARSAW CHIROPRACTIC PATIENT INFORMATION FORM - CONFIDENTIAL!

SYSTEM REVIEW: please answer each of the following on any condition you **HAVE** or **HAVE HAD**:

Ear, Nose or Throat: No ☐ Yes ☐ Lung or Breathing: No ☐ Yes ☐ Heart or Circulation: No ☐ Yes ☐

Sinus Infections: No ☐ Yes ☐ Bleeding or Bruising: No ☐ Yes ☐ Cancer (any type): No ☐ Yes ☐

Diabetes: No ☐ Yes ☐ Stomache/Digestive: No ☐ Yes ☐ Arthritis: No ☐ Yes ☐

Joint replacement: No ☐ Yes ☐ Spine surgery: No ☐ Yes ☐ Spinal Injury: No ☐ Yes ☐

Nerve Damage: No ☐ Yes ☐ Fractures: No ☐ Yes ☐ Headaches or Migraines: No ☐ Yes ☐

Fibromyalgia: No ☐ Yes ☐ Chronic pain: No ☐ Yes ☐ Sleep Apnia: No ☐ Yes ☐

OTHER: ____

For TODAY'S VISIT, please provide the doctor with the following information:

My pain started (date)_______________ and TODAY is a **1 2 3 4 5 6 7 8 9 10** (10 is worse!)

I HAVE: Never had this pain before:_____ Felt like this before: _______ Never had it hurt this bad______

MY PAIN IS: Getting worse:______ Getter better: ______ Staying the same:_______ I can't tell:__________

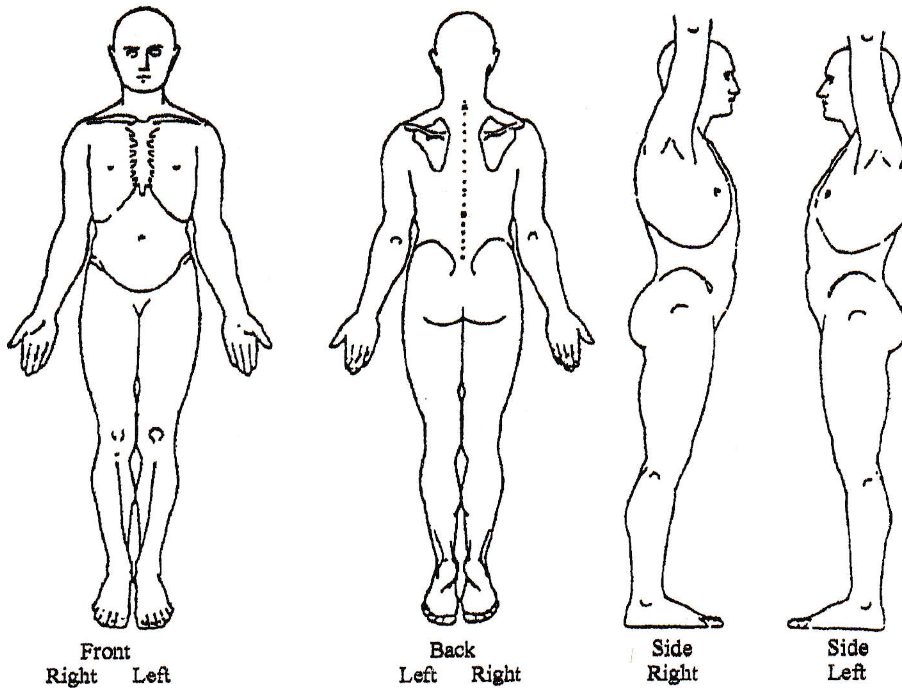
MY PAIN IS: Sharp___ Dull___ Throbbing___ Numb___ Aching___ Shooting___ Burning____ Cramping___

MY PAIN: Constant____ Frequent____ On/Off____ Rare____

MY PAIN INTERFERES WITH: Work___ Sitting___ Sleeping___ Daily activities___ Recreation___ Other:________

MY PAIN DECREASES WITH: Heat___ Cold___ Rest___ Pain medication ___ Other:_____________ Nothing___

Please CIRCLE or place an X on any areas of pain or concern on diagrams below: ↓ ↓ ↓ ↓ ↓ ↓



I have provided all my health information Dr. Henderson:**______________________________**

WARSAW CHIROPRACTIC –Dr. Darron Henderson, DC

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me. I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

_______________________	_______________________	____/____/_____
Printed Name	**Signature**	**Date**

Financial Policy

Warsaw Chiropractic – Dr. Darron Henderson, D.C.

Please review applicable section below:

- **Self-pay*:*** Payment is due in full at the Time of Service in order to receive a "Time of Service" discount.
- **Medicare:** Pays 80% of the allowable fee ***once deductible is met***. You are required to pay the deductible and the remaining 20%, as well as any non-covered services. Supplemental insurance may pay deductible and/or copay. Please provide card(s) to front desk upon arrival.
- **Group or Individual Insurance:** If we are ***"out-of-network"*** for your insurance, payment in full is due at the time of service. We will file a claim for you on your behalf. If we are ***"in-network,"*** when possible, we will call to verify your benefits. However, the benefits quoted by your insurance company are not a guarantee of payment. Payment will be due by you at or following the time of service for any non-covered services, deductibles or co-pays.
- **Worker's Comp/Personal Injury/Motor Vehicle Accident:** You must provide all pertinent billing information prior to any treatment.

Insurance One Time Authorization

I understand that my insurance is an arrangement between myself and my insurance company, ***NOT*** between Warsaw Chiropractic – Dr. Darron Henderson, D.C. and my insurance company. I request that Warsaw Chiropractic prepare the customary forms, including any additional information requested, so that I may obtain insurance benefits. I also understand that if my insurance company does not respond within 30 days, or if I suspend or terminate my schedule of care as prescribed by Dr. Darron Henderson, D.C. that fees will be due and payable immediately. I authorize that any insurance benefits or reimbursement for services rendered which amounts would otherwise be payable to me under any insurance or pre-paid health care plan be made directly to Warsaw Chiropractic- Dr. Darron Henderson, D.C.

Payment Agreement: I understand that there is no guarantee that my insurance or pre-paid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

Unpaid Balance: *I understand if I have an unpaid balance to Warsaw Chiropractic- Dr. Darron Henderson, D.C., and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.*

In order for Warsaw Chiropractic- Dr. Darron Henderson, D.C. or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Warsaw Chiropractic- Dr. Darron Henderson, D.C. and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

Assignment & Release: I, the undersigned certify (for myself or dependent) that I have insurance as reported and assign to Dr. Darron Henderson directly all insurance benefits, if any otherwise payable by me for all services rendered. I understand that I am financially responsible for ALL charges prior to submission to insurance companies. I hereby authorize the doctor to release any and all information necessary to secure payment of benefits. I authorize my "on-file" signature to be used on all insurance claims.

____ ____________________

Signature of Patient/Legal Guardian Date

Acknowledgement of Warsaw Chiropractic's

Notice of Privacy Practices

I acknowledge that I have been informed of Warsaw Chiropractic's Notice of Privacy Practices located on the wall by the reception desk.

Patient Signature: ____

Legal Representative Signature: __________________________________

Relationship to Patient: _______________ Date: _______________

I hereby authorize the below listed individual's access to my health information:

Individual	Relationship	Phone #
____________________	______________	____________________
____________________	______________	____________________
____________________	______________	____________________

Patient or legal representative was unwilling/unable to sign acknowledgement.

Reason:

____

____

Staff Signature: ______________________________ Date: _____________