

Welcome to Dr. J. J. Levine's office. Prepare for health!

Last Name: _____	First Name: _____	M.I.: _____
Street: _____	Apt. #: _____	
City: _____	State: _____	Zip Code: _____
Email (for our office use only): _____		
Home Phone: (____) _____ - _____	Work Phone: (____) _____ - _____	ext. _____
Cell phone: (____) _____ - _____	Fax Line: (____) _____ - _____	
Birth date: __/__/__	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	SSN: ____ - ____ - ____
Height _____		Weight _____
<input type="checkbox"/> If married, spouse's name: _____ & spouse's birth date: ____/____/____		
Emergency contact's name: _____		
Relationship to patient: _____		
Emergency contact's home: (____) _____ - _____ and their cell: (____) _____ - _____		
# of children: ____ Names and ages: _____		
How did you hear of us, or whom may we thank for referring you? _____		

Have you had an accident (major or minor) within the past 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what type of accident? <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Other: _____
If yes, what date & time did this accident occur? ____/____/____ ____:____ am pm
If you are seeking care due to an accident it is possible care may be provided at no out of pocket cost to you. If seeking care due to an injury please ask the receptionist for the "accident questionnaire" at this time.
<input type="checkbox"/> I am <input type="checkbox"/> I am not seeking care due to an auto or work injury Initial here _____

Do you have health insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a secondary insurance policy? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please provide the receptionist with your insurance card(s) <u>now</u> . She will make a photocopy and our office will inform you of your coverage. Most insurance companies <u>cover</u> our services.
Primary insured's name: _____ their SSN ____ - ____ - ____ & birth date ____/____/____
Relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____
Your marital status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> Legally Separated
Your student status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Non-student
Your employment status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired
Your employer: _____ Spouse's employer, if married: _____
I realize my health insurance company will be billed as a service to me. Until my benefits can be verified, I will be responsible for payment of care today. If I have coverage, the amount I pay today will be applied to my deductible and/or my daily co-insurance payments. If I do not have coverage the doctor will discuss an affordable plan with me. I may also be asked to help pursue the insurance company in small claims court if necessary.
Initial here _____

Your initial visit today will include an extended evaluation with Dr. J. J. Levine. If necessary, x-rays will be taken. The fee for today's visit is \$100.00. I will pay with: <input type="checkbox"/> Cash <input type="checkbox"/> Credit card <input type="checkbox"/> Check
Signature _____ Today's date ____/____/____

FEE SCHEDULE APPLIED TO ALL INSURANCE COMPANIES

The average office visit fee applied to all insurance companies is approximately \$199.00. You are only responsible for a daily co-insurance payment and payment(s) toward any remaining annual deductible you may have. Our office will discuss your financial responsibility with you.

Initial new patient evaluation/consultation 2 nd opinion (99273)	\$190.00
Initial new patient detailed evaluation/consultation (99203)	\$150.00
X-ray series of 5 (72040-72100)	\$250.00
Report of x-ray/orthopedic findings between doctor and patient (99272)	\$150.00
Muscle Testing (95831 or 97750)	\$150.00
Computerized Range of Motion Test w/ report (95851)	\$210.00
Extended daily re-examination/evaluation of patient (99213-25)	\$ 70.00
Computerized neurological/temperature graph instrumentation (93740)	\$ 40.00
3-4 region spinal adjustment/CMT (98941)	\$ 55.00
Therapeutic exercise (97110)	\$ 45.00
Therapeutic activities (97530)	\$ 46.00
Neuromuscular re-education (97112)	\$ 35.00
Myofacial release (97140)	\$ 44.00
Cold or hot therapy spray (97010)	\$ 20.00

The above fees are based on Fee Facts pricing, a consensus and poll of doctors fees nationwide
Many of the above fees are billed to the insurance company on the same date of service

I understand the average daily office visit fee applied to all insurance companies is \$199.00.

I understand each code and/or multiple codes above will be billed to my insurance company on the same date of service. I accept these fees and understand the doctor is to be paid in full for all services I receive. I understand, as a service to me, the doctor pays a billing service and a documentation service then awaits reimbursement from my insurance company. By signing below, I make known the co-insurance payment of my care would be a financial hardship to me.

I am only responsible for a daily co-insurance payment and payment(s) toward my annual deductible, while my health insurance is being billed.

I understand if my care is associated with an injury/accident claim, all bills will be paid at 100% of the above fee schedule regardless of the outcome of my case. I understand automobile insurance companies and worker's compensation companies pay for auto/work injury care in full.

I understand most auto and work injury care is provided at no out of pocket cost to me.

I further agree, if any insurance company refuses payment, to authorize the doctor to file suit in small claims court, on my behalf, against the insurance company, as a method of collection. I agree to be present at the court date if needed.

I have fully read and understand these terms and fees.

Patient's signature

Print your name

____/____/____
Today's date

Health History Questionnaire

Last Name: _____ First: _____ MI: _____

What name do you prefer to go by? _____

Birth date ___/___/___ Age: _____ SSN: _____ - _____ - _____

Are you pregnant? n/a (male) No Unsure Yes, due date ___/___/___

X-rays taken w/in the last year? No Yes date ___/___/___ Reason _____

Doctor's name & phone where x-rays were taken: _____

List medications, vitamins, birth control: _____

List allergies: _____ List fractured bones: _____

List surgeries & organs removed: _____

Do you have any concerns about chiropractic care? No Yes, _____

Do you have any concerns about therapy/rehabilitation? No Yes, _____

Description of your Current Chief Complaint

Are you here for: a checkup a specific problem

What is your #1 specific chief complaint? _____

What date did your chief complaint begin? ___/___/___

What were you doing when this pain first appeared? _____

Have you had this problem before? No Yes explain _____

Where specifically is your chief complaint located? _____

Is your pain: constant comes and goes other _____

What activities make your chief complaint better? _____

What activities make your chief complaint worse? _____

What position relieves this pain? _____

How often is your problem present 0-25% 26-50% 51-75% 76-100%

Does pain interfere w/ work/living habits? No Yes, how _____

What have you done for the pain yourself? _____

Check each box that describes **the chief complaint** you discussed above: dull
 sharp pain numbness tingling stiffness throbbing aching shooting
 burning cramping radiating pain from _____ to _____
 swelling redness other _____

Circle your pain level on this pain scale 0 = no painup to.... 10 = intolerable pain
no pain 0... 1 2 3 4 5 6 7 8 9 ...10 intolerable pain

Does your **chief complaint/pain** become worse at night? Yes No

It is better in the: AM MIDDAY PM Never lessens

It is worse in the: AM MIDDAY PM It is constant

Does your chief complaint interfere with your sleep? Yes No

By signing below, I certify the above information is complete and accurate to the best of my knowledge. Inaccurate information could be dangerous to my health.

Patient's signature

Today's initial consultation date

Health History Questionnaire Page 2

Last Name: _____ First: _____ MI: _____

Have you consulted/received other treatment for your chief complaint/condition?

No Yes If yes, what treatments? _____

Name & phone of treating Dr. _____

Doctor's/care giver's specialty? _____

Result of treatment, did it help you? Yes No _____

List any major or minor accidents/trauma fall auto sport other Describe & list dates: _____

In addition to the chief complaint you described on page 1, do you have any **other problems or pain** you would like to address? Please list them in order of importance: 1. _____ 2. _____ 3. _____

Check all that apply to you:

<input type="checkbox"/> Colds	<input type="checkbox"/> Loss of energy	<input type="checkbox"/> Digestive trouble
<input type="checkbox"/> Seizures	<input type="checkbox"/> Headaches	<input type="checkbox"/> Asthma/lungs weak
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Hip pain	<input type="checkbox"/> Hearing problems
<input type="checkbox"/> Mid back pain	<input type="checkbox"/> Cramps	<input type="checkbox"/> Neck pain
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Low back pain	<input type="checkbox"/> Trauma _____
<input type="checkbox"/> Prostate issues	<input type="checkbox"/> Shoulder pain	<input type="checkbox"/> Low blood pressure
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart disease	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Sore throats	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Gall bladder issues
<input type="checkbox"/> Cancer/tumor	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Kidney problems
<input type="checkbox"/> Aortic aneurysm	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Abnormal weight loss/gain
<input type="checkbox"/> Stroke: date ____/____/____	<input type="checkbox"/> Leg pain/cramps	<input type="checkbox"/> Other _____
<input type="checkbox"/> Back/spinal condition or disorder describe: _____		

Check all that apply to your family history: Osteoporosis Stroke Seizures
 Cancer Diabetes Abnormal blood pressure Cardiovascular disease

Dr. J.J. Levine's Mission

Your nervous system is made up of your brain, spinal cord & nerves. Your nervous system is in charge of directing, controlling, & coordinating every organ & system in your body. If you have a misaligned spinal bone, the nerves exiting through that spinal bone are not operating at their best. I detect this, then gently & manually perform spinal adjustments to remove spinal cord interference (Subluxations). Once adjusted the nerve tracts are no longer compressed & your nervous system can work at its optimum. Ultimately homeostasis & health are restored naturally to every organ, system, tissue & cell in your body. I have over six years of schooling in anatomy, physiology, the central nervous system, etc. I have had the honor of helping thousands of patients & their families, here in Tempe, since 1991. I do not diagnose nor claim to cure disease. Instead, I choose to assist your body's inborn (innate) healing ability to occur on its own. By signing below I consent to care as explained and I certify my information above is complete & accurate.

Patient's signature

Today's date

Health Care Authorization Form (HIPPA Privacy Practices)

Here at Dr. J. J. Levine's office we ask you for a few specific authorizations

All information you provide to us is confidential in nature and will only be referenced when contacting you, the insurance company, or another relative facility. By signing this form I give permission to **Dr. Jonathan J. Levine's Office** to use all information I provide, as this office deems appropriate.

By signing below I give this office permission to:
Send me birthday cards, holiday-related cards, and thank you cards and gifts.
Call me and/or leave messages for me on an answering machine.
Provide me information on treatment and other health related information.
Allow staff and other patients to view my name on the sign in register.
When I refer another patient, list my name in the monthly newsletter for recognition.
Take my picture for the "well adjusted patients" bulletin board that is inside the office.
Treat me in a semi-open room where others may see me if passing by in the hall.
File a health care provider lien to bind insurance companies to forward payment.
Display any testimonial I may write in order to share my success with others.

I am aware other persons in this office may overhear my protected health information during the course of care. I also understand my information may be overheard by other patient's at the front desk or in other areas of the office. Should I need to speak with the doctor privately at any time, the doctor will provide a room for these conversations.

By signing this form I am giving **Dr. Jonathan J. Levine's Office** permission to use and disclose my private protected information in accordance with the directives listed above.

Acknowledgement of Receipt of Notice Of Privacy Practices

Please feel free to read the binder located on the front reception counter. I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand I have the following rights and privileges:
I have the right to review the notice prior to signing this consent.
I have the right to object to the use of my health information for directory purposes.
I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

This authorization shall expire on the following date: No expiration date

The patient identified below authorizes Dr. Jonathan J. Levine's Office to use & disclose protected health information in accordance with all items described.

Patient's signature: _____

Please print your name: _____

Patient's SSN: _____ **Date of Birth:** ____ / ____ / ____

Today's Date: ____/____/____

To Whom It May Concern:

I am currently insured with your health insurance company.

I began care with Dr. Jonathan J. Levine, today. He informed me of a possible delay in processing claims until you receive the following information from me.

Please allow my letter to serve as my written notification that I am not insured with any other party or carrier. And I am not under care for any accident or injury. Please note the following in my record and in your system:

- I am not insured with any other health insurance carriers or companies.
- I have no other health care insurance.
- Your company is my sole health insurance company and responsible for providing payment for the health care I receive.
- I am not seeking care due to an automobile accident.
- I am not seeking care due to a work related injury.
- I am not seeking care for any third party accident/injury claim.

Thank you for entering this information into your system, on my behalf, and for processing my claims with Dr. Jonathan J. Levine without delay. I've provided my signature and listed my personal information below, for your convenience, when processing my information into your system.

Sincerely,

My signature

My printed name

My Address: _____

My ID/Policy# with you: _____

My Group #: _____

My SSN#: _____

My Date of Birth: ____/____/____

My Phone: _____

**NOTICE TO INSURANCE COMPANY OF ASSIGNMENT
AUTHORIZATION TO ISSUE CHECKS OR DRAFTS TO DOCTOR'S OFFICE**

To: _____
Insurance Company responsible for payment

1. I _____ ID# _____
Patient's name

do hereby **AUTHORIZE AND DIRECT** any and all checks or drafts relative to treatment rendered by Dr. Jonathan J. Levine, which are issued by the above named insurance company, and which represent sums payable to me, the patient, or on my behalf be made payable to the order of:

Dr. Jonathan J. Levine
3330 South Price Road, Suite D-110
Tempe, Arizona 85282

I authorize all relative health care payments be made out to doctor and forwarded to doctor's office.

2. I further **AUTHORIZE AND DIRECT** you to send all of said checks or drafts to:
Dr. Jonathan J. Levine
3330 South Price Road, Suite D-110
Tempe, Arizona 85282

3. I further **AUTHORIZE AND DIRECT** Dr. Jonathan J. Levine to provide care to me and to release all health care information necessary for the processing and payment of any health insurance claim he submits.

4. I understand Dr. Jonathan J. Levine is providing care and waiting for reimbursement from the insurance company as a service to me. In order for this service to continue I hereby grant Dr. Jonathan J. Levine, Power of Attorney to negotiate any draft or check amount for the services rendered by Dr. Jonathan J. Levine's office. In the event the insurance company denies payment, Dr. Jonathan J. Levine may retain the unpaid balance of his bill for all care provided to me in this office, through small claims court, at 100% of his billing. Any amount paid out of my pocket for relative dates of service will be forwarded to me, the patient, directly, after the doctor's bill has been satisfied in full.

5. Our office will make every effort to collect from the insurance company. Our success rate is excellent. However, if these efforts are exhausted, and the services of a collection agency become necessary, I understand I will be responsible for the agency fees at thirty percent of my total bill (the insurance company will be billed first).

6. In the event any insurance company obligated by contracted agreement to make payment to me or to Dr. Jonathan J. Levine refuses to make such payment upon demand by Dr. Jonathan J. Levine, D.C., I hereby agree to sign a small claims action at that time, or personally reimburse the doctor and pay my balance in full at that time. If Dr. Jonathan J. Levine is not reimbursed within a reasonable amount of time from the date of dismissal from this office or if I do not reimburse him directly and pay my balance in full, I hereby assign and transfer Dr. Jonathan J. Levine, the cause of action that exists in my favor against any such insurance company, and authorize Dr. Jonathan J. Levine to prosecute said action, either in my name or the insurance company's name, and further authorize Dr. Jonathan J. Levine to collect on his said portion of claim for amount of services he provides.

Patient's Signature
By signing above, the co-payment of my
Care would be a financial hardship on me.

_____/____/20_____
Date

Witness

PRE-EXISTING CONDITIONS

I understand my health insurance company will request this information, prior to paying Dr. J. J. Levine's office. Without this information my health insurance company may not pay Dr. J.J. Levine. Once requested, I understand this information will be forwarded to my health insurance company in order to assure payment to Dr. J. J. Levine.

PROVIDERS SEEN DURING LAST 12 MONTHS

<u>Provider & provider's address</u>	<u>Dates treated</u>	<u>Reason for treatment</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____
12. _____	_____	_____

Please use the back of this form if you need more space.

Sincerely,

_____	_____
Your Signature	Your Health Ins. ID #
Print your name: _____	
Your address: _____	
Your phone number: _____	
Your date of birth: _____	

Dr. J. J. Levine, D.C.
480.345.2080
3330 South Price Road Suite D-110 Tempe, AZ 85282

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name	Signature	Date
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Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

Signature	Date
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