

WELCOME TO INNATE LIFE CENTER

Last Name: _____		First Name: _____		M.I.: _____	
What name do you prefer to go by? _____					
Address: _____				APT #: _____	
City: _____		State: _____		Zip Code: _____	
Email (for office use only): _____					
Home Phone: (____) _____			Work Phone: (____) _____ EXT _____		
Cell Phone: (____) _____			Fax Line: (____) _____		
Date of Birth: ____/____/____		Sex: <input type="checkbox"/> M <input type="checkbox"/> F		SSN: _____	
		Height _____		Weight _____	
Spouse's name: _____				Phone: (____) _____	
Emergency contact other than Spouse:					
Name: _____		Relation: _____			
Home Phone: (____) _____			Cell Phone: (____) _____		
How did you hear about us/whom may we thank for referring you? _____					

Have you had an accident (major or minor) within the past 2 years? <input type="checkbox"/> NO <input type="checkbox"/> YES	
If yes, what type of accident? <input type="checkbox"/> AUTO <input type="checkbox"/> WORK <input type="checkbox"/> OTHER: _____	
If yes, what date and time did this accident occur? ____/____/____ :____ am pm	
<i>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 front desk for the "accident questionnaire" at the time.</i>	
Are you seeking care due to an auto of work injury? <input type="checkbox"/> NO <input type="checkbox"/> YES Initial Here: _____	

Do you have primary health insurance policy? <input type="checkbox"/> NO <input type="checkbox"/> YES	
Do you have a secondary health insurance policy? <input type="checkbox"/> NO <input type="checkbox"/> YES	
<i>If yes, please provide the front desk with your health insurance card(s) at this time and our office will inform you of your coverage. Most insurance companies cover our services.</i>	
Policy Holder's Name: _____ Date of Birth: ____/____/____ SSN: _____	
Relation to Policy Holder: <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 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. Jonathan J. Levine, D.C. 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 of Patient/Guardian	_____ Print Name	____/____/____ Date

HEALTH HISTORY QUESTIONNAIRE

PATIENT'S FULL NAME: _____

Are you pregnant? N/A (male) No Unsure Yes, Due Date: ___/___/___

Have you had x-rays within the last year? NO YES If Yes, date: ___/___/___

Reason: _____

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

List any medications (including birth control) or vitamins you are currently taking:

List Allergies: _____

List Fractured Bones: _____

List Surgeries or Transplants: _____

List major/minor accidents trauma: _____

Do you have any concerns about chiropractic care? NO YES, _____

Do you have any concerns about therapy/rehabilitation? NO YES, _____

Check all that apply:

- Headaches Osteoporosis Hearing Problems Ringing in Ears
- Depression
- Neck Pain Sore Throats Aortic Aneurysm Vision Problems Dizziness
- Shoulder Pain Nervousness Heart Disease Low Blood Pressure Trauma
- Upper Back Pain Seizures Kidney Problems High Blood Pressure Cold
- Mid-Back Pain Loss of Energy Cancer/tumor Digestive Trouble Diarrhea
- Low Back Pain Constipation Gall Bladder Issues Asthma/Weak lungs HIV/AIDS
- Hip Pain Cramps Prostate Issues Urinary Tract Infections Diabetes
- Leg Pain/Cramps Arthritis/rheumatism Difficulty Sleeping Stroke: date: ___/___/___ Tonsillitis
- Back/Spinal Condition, please describe disorder: _____
- Abnormal weight gain/loss Other: _____

Family Medical History: Please check all the apply

- Cancer Stroke Seizures Diabetes Abnormal Blood Pressure
- Osteoporosis Cardiovascular Disease

Current Chief Complaint:

Are you here for: a check up a specific problem: _____

What were you doing when this complaint first appeared: _____

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

HEALTH HISTORY QUESTIONNAIRE CONT'ed

Have you had this complaint before? NO YES, _____

Where specifically is your complaint located? _____

Is your complaint: Constant Comes and Goes Other: _____

What activities make your complaint better? _____

What activities make your complaint worse? _____

What position relieves this complaint? _____

How often is your complaint present (please circle)? 0-25% 26-50% 51-75% 76-100%

Does this complaint interfere with work/living habits? NO YES, _____

What have you done for this complaint? _____

Check each box that describes the chief complaint you discussed above:

Dull Pain Sharp Pain Numbness Tingling Stiff Throbbing Aching
 Shooting Burning Cramping Swelling Redness Radiating: From: _____ to _____

Please circle your pain level on this scale: **0 = no pain...up to...10 =intolerable pain**

0 1 2 3 4 5 6 7 8 9 10

My complaint is:

Better in the: AM MIDDAY PM Never Lessons

Worse in the: AM MIDDAY PM Constant

Does your complaint interfere with your sleep? NO YES

Have you consulted/received other treatments for your chief complaint? NO YES

If yes, what treatments: _____

Result of treatments: _____

Name/ Phone number of treating doctor: _____

Treating doctor's specialty: _____

Are there any other problems/pains that you wish to address during this visit? NO YES

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

_____ / ____ / ____

Signature of Patient/Guardian

Print Name

Date

HIPPA Health Care Authorization Form (Privacy Practices)

All information you provide us with is confidential in nature and will only be referenced or shared with you, insurance companies, providers and billing or legal facilities who provide us with a signed request. By signing this form I give permission to **Dr. Jonathan J. Levine, D.C.'s** Office to use all information I provide, as this office deems appropriate.

In addition, by signing below I give this office permission to:

- ❖ Send me correspondence and provide me with health & other related information.
- ❖ Call and/or leave messages for me on an answering machine and/or voicemail.
- ❖ Provide health care professionals & others with my information when requested.
- ❖ Allow staff and other patients to view my name on the sign in register/sheet.
- ❖ 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 testimonials I may write.
- ❖ Forward to/request my records from providers, attorneys & insurance companies.

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, D.C.'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 in 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, D.C.'s Office to use and disclose protected health information in accordance with all items described.

Print Patient Name: _____ Date of Birth: ____/____/____

_____/_____/_____
Signature of Patient/Guardian Print Guardian Name, *if applicable* Date

FEE SCHEDULE APPLIED TO ALL INSURANCE COMPANIES

The average office visit fee applied to all insurances is 199.00

You are only responsible for a daily co-payment and, if applicable, payment(s) toward any remaining annual deductible. Our office will discuss your financial responsibly with you.

FEE SCHEDULE APPLIED TO ALL INSURANCE COMPANIES	
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 with 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 activates (97530)	\$46.00
Neuromuscular re-education (97112)	\$35.00
Myofacial release (97140)	\$44.00
Cold or Hot therapy spray	\$20.00

The above fees are based on Fee Facts pricing, a consensus/poll of doctor's 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-payment and, if applicable, payments(s) toward my annual deductible, while my health insurance is being billed.

I understand if my care is associated with an auto, work, injury or 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 and worker's compensation insurance pay for the accident care in full. **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 also agree to filing a lien all insurance companies responsible for payment. **I have fully read and understand these terms and fees.**

_____/_____/_____
Signature of Patient/Guardian Print Name Date

**NOTICE TO INSURANCE COMPANY OF ASSIGNMENT
AUTHORIZION TO ISSUE CHECKS AND DRAFTS TO DOCTOR**

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, D.C., 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, D.C.

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, D.C.

3330 South Price Road, Suite D-110

Tempe, Arizona 85282

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

4. I understand Jonathan J. Levine, D.C. 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, Jonathan J. Levine, D.C., Power of Attorney to negotiate any draft or check amount for the services rendered by Jonathan J. Levine, D.C.'s office. In the event the insurance company denies payment, Jonathan J. Levine, D.C. 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 the put of 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 he 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).

In the event any insurance company obligated by contracted agreement to make payment to me or to Jonathan J. Levine, D.C. refuses to make such payment upon demand by 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 Jonathan J. Levine, D.C. 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 Jonathan J. Levine, D.C., the cause of action that exists in my favor against any such insurance company, and authorize Jonathan J. Levine, D.C. to prosecute said action, either in my name or the insurance company's name, and further authorize Jonathan J. Levine, D.C. to file a lien and collect on his said portion of the claim for amount of services he provides.

By signing below the co-payment of care would be a financial hardship to me:

Witness: _____

A copy of this form shall be sent to all payers & copies shall be as valid as the original

_____/_____/_____
Signature of Patient/Guardian Print Name Date

PRE-EXISTING CONDITIONS

PLEASE LIST THE PROVIDERS YOU'VE SEEN DURING THE LAST 12 MONTHS

Provider's Name: _____
Address & Phone: _____
Dates treated: _____
Reason for treatment: _____

Provider's Name: _____
Address & Phone: _____
Dates treated: _____
Reason for treatment: _____

Provider's Name: _____
Address & Phone: _____
Dates treated: _____
Reason for treatment: _____

Provider's Name: _____
Address & Phone: _____
Dates treated: _____
Reason for treatment: _____

Provider's Name: _____
Address & Phone: _____
Dates treated: _____
Reason for treatment: _____

Provider's Name: _____
Address & Phone: _____
Dates treated: _____
Reason for treatment: _____

Please use the back of this form if more space is needed

I understand my health insurance company may request this information, prior to paying Dr. Jonathan J. Levine, D.C. Without this information my health insurance company may not pay Dr. Jonathan J. Levine, D.C. Once requested, I understand this information will be forwarded to my health insurance company,

Our office will fill in your information here: ID/Policy #: _____ Group #: _____ Date of Birth: ___ / ___ / ____

Signature of Patient/Guardian **Print Name** ___ / ___ / ____
Date