Chestnut Hill Chiropractic & Rehabilitation

Dr. Robert Gensler
60 Kendrick St. Suite 204
Needham, MA 02494 P: (617) 332-5105
www.chestnuthill-chiropractic.com

# Confidential Patient Information

Name: _____ Date of Birth: _____
First Last

Address: _____ Sex: M ☐ F ☐
# Street (apt #)

City: _____ State: _____ Zip Code: _____

Phone #: _____ Cell Phone #: _____

Email: _____ Marital Status: M ☐ S ☐ D ☐ W ☐

SS #: _____ Student: Full-Time ☐ Part-Time ☐ Children: Yes ☐ No ☐ # ☐

Occupation: _____ **Best Place to reach you?** Cell ☐ email ☐ phone ☐
(we may contact you about scheduling or billing)

Insurance Company: _____ Policy #: _____

Group #: _____ Ins. Subscribers Name & D.O.B: _____

Is this visit related to an accident? Yes ☐ No ☐ Who referred you to us? _____

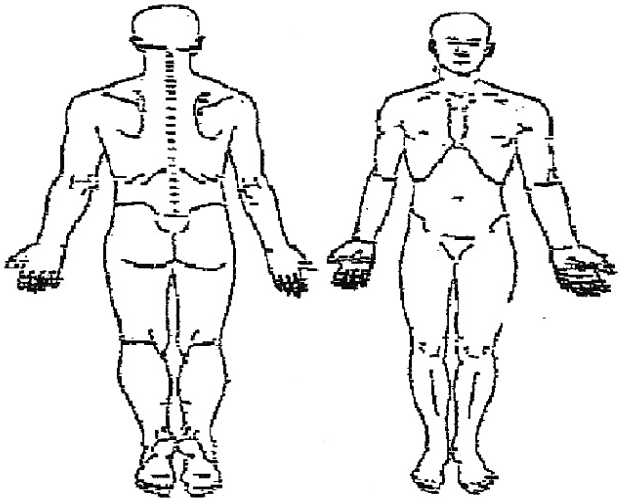
Emergency Contact: _____ Emergency Contact Phone # _____

## Major Complaints & Symptoms

What is your primary physical complaint? _____ Is this the first occurrence? _____
What aggravates these symptoms? _____
What decreases these symptoms? _____

On a scale of 1 to 10, how strong is the pain now? (1 being no pain and 10 being severe pain)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10



Using the symbols provided below, mark the areas on the illustrations where you are experiencing these sensations.

| | |
|---|---|
| BURNING | XXXXXXXXXXX |
| STABBING | /////////////// |
| PINS & NEEDLES | ********** |
| ACHING | 00000000000 |
| NUMBNESS | - - - - - - - - - - - |

**Today's Date:** _____

↓ **PLEASE RATE YOUR SYMPTOMS IN ORDER OF SEVERATY 1, 2, OR 3 ( 1 being the LEAST severe, 3 being the MOST )** ↓

- ☐ Headaches L ☐ R ☐
- ☐ Jaw Pain L ☐ R ☐
- ☐ Neck Pain L ☐ R ☐
- ☐ Shoulder Pain L ☐ R ☐
- ☐ Mid Back Pain L ☐ R ☐
- ☐ Elbow Pain L ☐ R ☐
- ☐ Wrist Pain L ☐ R ☐
- ☐ Hand Pain L ☐ R ☐
- ☐ Abdominal Pain
- ☐ Hip Pain L ☐ R ☐
- ☐ Low Back Pain
- ☐ Leg Pain
- ☐ Knee Pain
- ☐ Ankle Pain
- ☐ Foot Pain
- ☐ Other _____ _____ _____ _____

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# Insurance Policy

**Please verify your insurance benefits related to chiropractic services.** We will submit claims for our services to your insurance company; however, you will need to verify your benefits so that you are aware of what benefits you have.

**Please inform us about any changes to your insurance policy as soon as they are made.** If you receive a new card, please show us upon your next visit so we can process your insurance claim correctly. Policy changes can occur at any time of year. **Note:** Medicare does not pay for any personal injury claims.

Some policies require a referral from your Primary Care Physician (PCP) or other authorization to cover your visits. Please check to see if this is a requirement for your policy.

Deductibles and co-payments are an out of pocket expense. When your insurance company processes your visits toward your deductible, you will be asked to pay us for those visits. **Payment for our services are due at the time of your appointment.** You may select to pay for a group of visits together if your co-payments are small, or if your visits are frequent.

Insurance claims need to be filed within 90 days of service. CHC will not retroactively file claims if you do not present us with the insurance info at the date of service. We may ask for your assistance if your insurance company does not submit a payment. **You will be billed for any unpaid claims that we are unable to collect.**

I have read the above policy and I agree to these terms.

Patient Name: _____

Patient Signature: _____

Date: _____

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# Statements

## Acknowledgement of Privacy Practices

I am aware that Chestnut Hill Chiropractic & Rehabilitation has specific privacy practices to ensure the proper use and handling of my personal medical information. I understand that I have access to my own copy of the "Notice of Privacy Practices" at the front deck upon request.

## Authorization to Release Medical Information

I hereby authorize the release of medical information pertinent to my case to the insurance company, or to an attorney involved in my case. I further authorize the release of my medical records and reports TO Chestnut Hill Chiropractic and Rehabilitation.

## Assignment of Benefits

I hereby authorize insurance company reimbursements to be paid directly to Chestnut Hill Chiropractic & Rehabilitation at 180 Wells Avenue, Suite 302A, Newton, MA 02459

## Financial Responsibility

I understand that I am fully responsible to Chestnut Hill Chiropractic & Rehabilitation for all charges that I incur at this practice. I understand, and agree, that If payment is not remitted by the insurance company and received by Chestnut Hill Chiropractic that I am responsible for the charges. Health and accident insurance policies are an agreement between an insurance carrier and myself.

Patient Name: _____

Patient Signature: _____

Date: _____