Robert W. Smith, DC, DABCI
Diplomate American Board Chiropractic Internist
4701 Bluebonnet Blvd., Suite B
Baton Rouge, LA 70809
Telephone 225-291-2626 Fax 225-291-2628

Welcome to our office.

In order to best meet your chiropractic needs, please complete the attached forms.

Payment is expected at time of service. For your convenience, we accept Visa, MasterCard and Discover in addition to cash and checks.

If you have health insurance, we will require a copy of your primary and secondary (if applicable) insurance card, front and back. Additionally, we will require a copy of your driver's license or identification card. We recommend that you also contact your insurance company to verify your coverage and benefits. Please understand that your insurance is a contract between you and your chosen insurance company. Therefore, you are responsible for knowing your own coverage. If you have questions about the insurance company, please feel free to contact my staff at 225-291-2626.

Insurance referral: If your insurance requires a referral from your primary care physician, this should be obtained prior to your first visit. No treatment can be rendered without this written referral.

Please fill out the Release of Records with the name and addresses of any specific physician or other person you would like to receive a copy of your evaluation.

We thank you for your cooperation and if you should have any questions, please feel free to contact my office.

Yours in health,

Robert W. Smith, DC, DABCI

Registration Form

PATIENT INFORMATION				
Patient's Last Name	First	Middle		Sex
Social Security Number	Home Phone ( )	Cell Phone ( )	Birth Date / /	Age
Street Address	City	State	ZIP	Email Address
Occupation			Employer	
Employer Address	City	State	ZIP	Work Phone Number ( )
Whom may we thank for referring you?	Ins Plan Patient	Phonebook Doctor	Close to home/work Other	
Primary Care Physician		PCP Address		PCP Phone
COMMERICIAL INSURANCE INFORMATION (Please give your insurance card(s) to the staff)				
Primary Insurance Company	HMO	PPO	Major Medical	Other
Subscriber's Name			Birth Date / /	Subscriber's SS
Policy Number		Group Number		
Patient's relationship to the subscriber (circle one): self spouse child other_____				
Secondary Insurance Company			HMO PPO	Major Medical Other
Subscriber's Name			Birth Date / /	Subscriber's SS
Policy Number		Group Number		
Patient's relationship to the subscriber (circle one): self spouse child other_____				
IN CASE OF EMERGENCY				
Name of Local Friend or Relative	Home Phone ( )	Cell Phone ( )	Relationship to patient	

The above information is true to the best of my knowledge. I assign directly to Robert W. Smith, DC, DABCI/Millervillage Chiropractic Center, APCC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X _____

Patient/Guardian Signature Date

Account Number: _____ Initials: _____ Date Received: _____

Health History

Patient's Last Name First Middle	Sex	Birth Date / /
What is the reason for your visit today? Briefly describe your symptoms & list other doctors seen or treatment given for this condition.		
What do you think caused this problem?		
List physicians seen within the last year Physician Condition		
Please list any current medical conditions or symptoms you are currently experiencing, or have experienced during this past year		
Please tell us about any hospitalizations, serious illnesses or surgeries: Year Reason Hospital Outcome		

Health History, page 2

Patient's Last Name First Middle	Sex	Birth Date / /
List your prescribed medications, over-the-counter medications and inhalers:		
Name	Dosage	Frequency Used
List your herbs, vitamins and homeopathics:		
Name and Brand	Dosage	Frequency Used
Please provide details of any known allergies. (e.g. latex, medications, foods)		
Allergen	Reaction	

Family Health History

Patient's Last Name	First	Middle	Sex	Birth Date / /

Please help us to identify your potential health risks by placing a check in any column that applies to you or your blood relatives.

Condition	Self	Grandparent	Father	Mother	Sibling	Child	Child
Age	Age ( )	Age ( )	Age ( )	Age ( )	Age ( )	Age ( )	Age ( )
AIDS/HIV							
Arthritis							
Asthma							
Back Pain							
Bleeding Disorders							
Bursitis							
Cancer							
Cancer							
Circulatory Problems							
Diabetics (type 1 or 2)							
Disc Problems							
Ear, Nose, Throat							
Endocrine/glandular (thyroid)							
Gastrointestinal (intestine)							
Gastrointestinal (stomach)							
Genitourinary (kidney)							
Genitourinary (prostrate)							
Genitourinary (urinary)							
Headaches							
Heart Problems							
Hepatitis							
High Blood Pressure							
Immune							
Insomnia							
Migraines							
Muscle, Joint, Bone							
Nervousness							
Neurological (brain, nerves)							
Psychological							
Respiratory (lung, breathing)							
Sinus Trouble							
Skin							
Stroke/TIA							
Other							
Other							

Credit and Financial Policy

Taking care of our patients and restoring their health is our primary objective. Treatment recommendations are based on need. Please advise us if you are unable to fulfill this policy so that we may discuss and consider alternative payment options. We require payment at the time of service unless special arrangements have been made. Our fees comply with the UCR (usual, reasonable and customary) for this region. We accept cash, checks, Visa, MasterCard and Discover. For our patients who are unable to pay at the time of service, special arrangements are available upon request.

FOR PATIENTS WITH INSURANCE We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Payment of co-payments, coinsurance, deductibles and non-covered services are expected at the time of service. We cannot promise that an insurance company will pay for your care, even when it is preauthorized. We strongly urge you to contact your insurance company to verify your overage and benefits; sometimes-incorrect information is provided to us.

Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you. If the insurance company erroneously pays directly to the insured, the amount shall be forwarded to this office within three days.

MEDICARE PATIENTS We will bill Medicare for you. We will also bill secondary insurance carriers for you. All co-payments, coinsurance or deductibles are due and payable at the time service is provided. Medicare will only pay for spinal manipulation and does not cover other therapies, initial examination, and reexaminations, x-rays or other services and goods that may be necessary during care. These fees are the patient's responsibility and payment is expected at the time of service. These services will not apply to the patient's deductible.

NONCOVERED SERVICES Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

PERSONAL INJURY CASES and WORKER'S COMPENSATION If your complaint is the result of an automobile accident or work related accident, of if litigation is pending, please notify us. It is our policy to bill the attorney monthly and the insurance company upon each visit when we have an executed lien or letter of protection.

Instances will arise when we exhaust all reasonable efforts to secure payment from your insurance company, but the insurance company refuses payment. We will do our best to assist you in securing payment, but all balances are ultimately your responsibility.

MISSED APPOINTMENTS In fairness to other patients and the doctor, we require at least 24 hours' notice to cancel appointments. You may be charged for missed appointments or dismissed from the practice. If more than three appointments are missed without notification, we will recommend that you seek treatment at another facility, or schedule care when you are able to commit to the recommended treatment program.

In fairness to our patients who do pay for service, after reasonable efforts on our part to obtain payment, we will solicit the services of a collection agency.

I have read and understand that I am financially responsible for all unpaid balances for my care. I have read, understood, and agreed to the above financial policy for payment of professional fees.

Patient's/Guardian signature_____ Date_____

Office Use Only:
Reviewed by _____ Acct #_____ Date_____

ASSIGNMENT OF INSURANCE BENEFITS Patients with insurance(s) please read and sign below.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Robert W. Smith, DC, DABCI/ MillerVillage Chiropractic Center APCC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient's/Guardian signature_____ Date_____

Release of Records

Date: _____

Patient Name: _____Date of Birth: _____

I request and authorize Robert W. Smith, DC, DABCI and/or MillerVillage Chiropractic Center, APCC to release my chiropractic records to the organization, agency, or individuals named below.

I certify that this request has been made voluntarily and that the information given is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that the action has already been taken to comply with it. Re-disclosure of my medical records by those receiving the authorized information may not be accomplished without further written consent. Without my expressed written revocation, this consent will automatically expire upon satisfaction of the need for disclosure, or not later than _____.

Please release my records to:

Primary Care Physician _____
_____

Other Physicians _____
_____

Attorney _____
_____

Myself/Other _____
_____

_____
Signature of Patient/Guardian

_____
Relationship to Patient

☐ I decline your offer to send records to any of the above and will advise you in writing if I wish you to do so in the future.

_____ _____
Signature of Patient/Guardian Date

Patient's Guide to Insurance Verification

We strongly encourage you to contact your insurance company to verify your chiropractic benefits. Please record all relevant information to crosscheck with our verification process. To cross-check this information, please contact our staff at 225-291-2626 or fax this form to our office at 225-291-2628.

You will find the customer service telephone number on the back of your insurance card. Please contact the company and ask the following questions about each service. Be sure to record the date, time, and name and telephone extension of the person you speak with.

Subscriber Name: _____

Subscriber Date of Birth: _____

Subscriber Social Security Number: _____

Patient Name: _____

Patient Date of Birth: _____

	Procedure	**Procedure Code**
Examination	99201-99205	□ Yes □ No
Spinal Manipulation	98940	□ Yes □ No
Electrical Muscle Stimulation	97014	□ Yes □ No
Hot/cold packs	97010	□ Yes □ No
Exercises and Stretches	97110	□ Yes □ No
Joint Mobilization	97140	□ Yes □ No
Traction	97012	□ Yes □ No

Please ask the customer service representative the following questions.

Are the recommended treatments covered? □Yes □No
Is my provider covered or part of your network?
□Yes □No If no, ask the following question –
Is there an out-of-network benefit? □Yes □No
Details:
Do I need a referral from my primary care physician? □Yes □No
Is there a co-payment? □No □Yes, Amount: _____
Is there a deductible? □No □Yes, Amount: _____
□Amount remaining to be met for this year? _____
Is there a coinsurance? □No □Yes, Amount: _____
How many treatments may I receive? _____
Is there a maximum allowable payment for each service?
□No □Yes, Amount: _____