PATIENT NAME (Last, First, Middle) _____

FINANCIAL: Cash / Insurance / Work Related / Medicare / Auto Accident / Attorney
DATE OF BIRTH: ____/____/_____ MARITAL STATUS: Single / Married / Divorced / Widow(er)

ADDRESS: _____

CITY: _____STATE: _____ ZIP CODE: ___ ___ ___ ___ ___

CELL PHONE: _____ ADD PHONE _____

SOCIAL SECURITY # ___ ___ ___ - ___ ___ - ___ ___ ___ ___ GENDER: Male / Female
EMAI: _____@_____
PATIENT'S EMPLOYER : _____
EMPLOYER'S ADDRESS:_____

NAME OF SPOUSE OR PARENT IF PATIENT IS A MINOR:_____
SPOUSE/PARENT EMPLOYER: _____
SPOUSE/PARENT SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___ PHONE #_____
SPOUSE/PARENT'S DATE OF BIRTH: _____/_____/_____

NAME OF INSURED: _____
INSURANCE COMPANY: _____ DATE OF BIRTH _____/_____/_____
SOCIAL SECURITY # _____ MEMBER # _____
GROUP # _____ EMPLOYER: _____

EMERGENCY CONTACT
NAME: _____ PHONE # _____
NAME: _____ PHONE # _____

I hereby authorize Greenawalt Chiropractic permission to treat _____.

_____ _____
Name Signature

HIPPA/MEDICAL INFORMATION RELEASE:
I am aware of the Health Insurance Portability and Accountability Act, and by signing below I am authorizing any of my health records/information may be disclosed to the following friends and/or family members:

NAME _____ RELATIONSHIP _____
NAME _____ RELATIONSHIP_____
NAME _____ RELATIONSHIP_____

_____ _____
DATE SIGNATURE

Name: _____

List present complaints in the order of what bothers you most:

1. _____ How Long? _____
2. _____ _____
3. _____ _____
4. _____ _____

List any doctor or facility consulted for complaints above: _____
Phone # _____ Address: _____

Have you had chiropractic in the past? Yes No When?_____ Where? _____

What Surgery have you had (use back of paper if you need to add additional info)

Type _____ Date _____ Dr. _____
Type _____ Date _____ Dr. _____
Type _____ Date _____ Dr. _____
Remarks _____

List any significant injuries (slips, falls, accidents, sports injury, and auto accident)

Type _____ Date _____
Type _____ Date _____
Type _____ Date _____
Remarks _____

List Fractures/Broken Bones

What _____ Date _____
What _____ Date _____
What _____ Date _____
Remarks _____

List all medications, vitamins, minerals, and/or diet supplements you take:

Name _____ Frequency _____ Quantity _____ by Dr. _____
Name _____ Frequency _____ Quantity _____ by Dr. _____
Name _____ Frequency _____ Quantity _____ by Dr. _____
Name _____ Frequency _____ Quantity _____ by Dr. _____
Name _____ Frequency _____ Quantity _____ by Dr. _____
Remarks _____

Allergies _____
Date of last Mammogram _____ **Last pneumonia vaccination**_____ **Flu shot** _____
Smoker Yes No Packs/Day _____ Former smoker Yes No Date you quit? _____

Family History(circle) Heart Disease High Blood Pressure Stroke Tuberculosis Cancer _____
Diabetes Kidney Disease Anemia Seizures

Circle any of the following you have experienced:

AIDS/HIV	Cancer	Epilepsy	Malaria	Pneumonia	STD's _____
Alcoholism	Chicken Pox	Goiter	Measles	Polio	Tuberculosis
Anemia	Diabetes	Heart Disease	Mental disorder	Rheumatic Fever	Typhoid Fever
Appendicitis	Diphtheria	Influenza	Mumps	Scarlett Fever	Whooping Cough
Arthritis	Eczema	Lumbago	Pleurisy	Small Pos	

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST FIVE YEARS:

GENERAL SYMPTOMS

Headache
Fever
Chills
Sweats
Fainting
Dizziness
Convulsions
Loss of sleep
Fatigue
Nervousness
Loss of weight
Numbness and tingling in arms, hand or legs
Allergy
Neuralgia

EYES, EARS, NOSE AND THROAT

Failing vision
Near sighted
Far sighted
Crossed eyes
Eye pain
Deafness
Earache
Ear noises
Ear discharge
Nose bleeds
Nasal obstruction
Sore throat
Hoarseness
Hay fever
Asthma
Dental decay
Gum trouble
Frequent colds
Enlarged thyroid
Tonsillitis
Sinus infection
Nasal drainage
Enlarged glands

SKIN

Skin eruptions
Itching
Bruises easily
Dryness
Boils
Varicose Veins
Sensitive Skin
Hives or allergy

RESPIRATORY

Chronic Cough
Spitting up blood
Spitting up phlegm
Chest pain
Difficult breathing

CARDIO-VASCULAR

Rapid beating heart
Slow beating heart
High blood pressure
Pain over heart
Previous heart stroke
Hardening of arteries
Swelling of ankles
Poor Circulation
Paralytic stroke

MUSCLE AND JOINT

Stiff neck
Back ache
Swollen joints
Tremors
Painful tail bone
Foot trouble
Pain between shoulders
Hernia
Spinal Curvature
Faulty posture

FEMALE ONLY

Painful menstrual period
Excessive flow
Hot flashes
Irregular cycle
Cramps or backache
Previous miscarriage
Vaginal discharge
Congested breast
Lumps in breast
Menopausal Symptoms

GENITOURINARY

Frequent urination
Painful urination
Blood in urine
Pus in urine
Kidney infection
Bed wetting
Inability to control urination
Prostate trouble

GASTROINTESTINAL

Poor appetite
Excessive hunger
Belching or gas
Nausea
Vomiting
Vomiting of blood
Pain over stomach
Distention of abdomen
Constipation
Diarrhea
Colon trouble
Hemorrhoids (Piles)
Intestinal worms
Liver trouble
Gall Bladder
Jaundice Colitis

_____

Please Initial

MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS. USE THE APPROPRIATE SYMBOL. INCLUDE ALL AFFECTED AREAS.

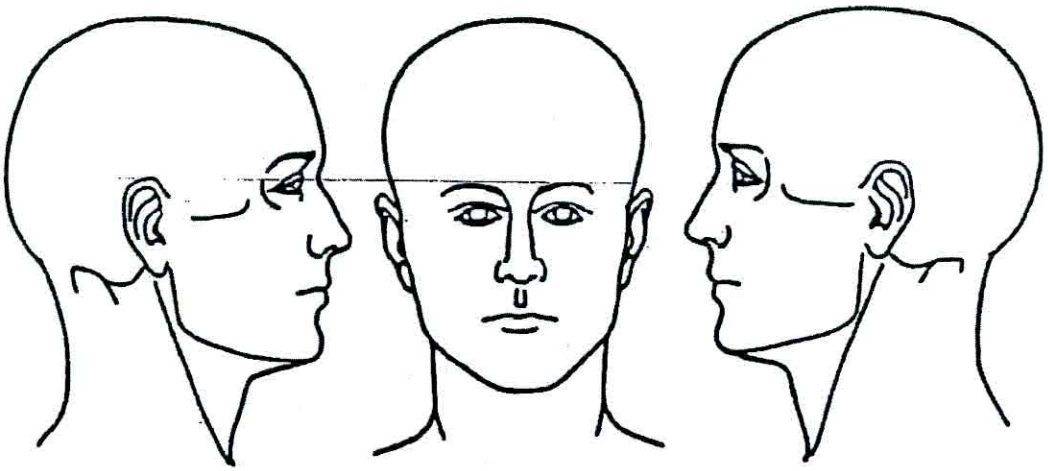
Numbness +++++
+++++

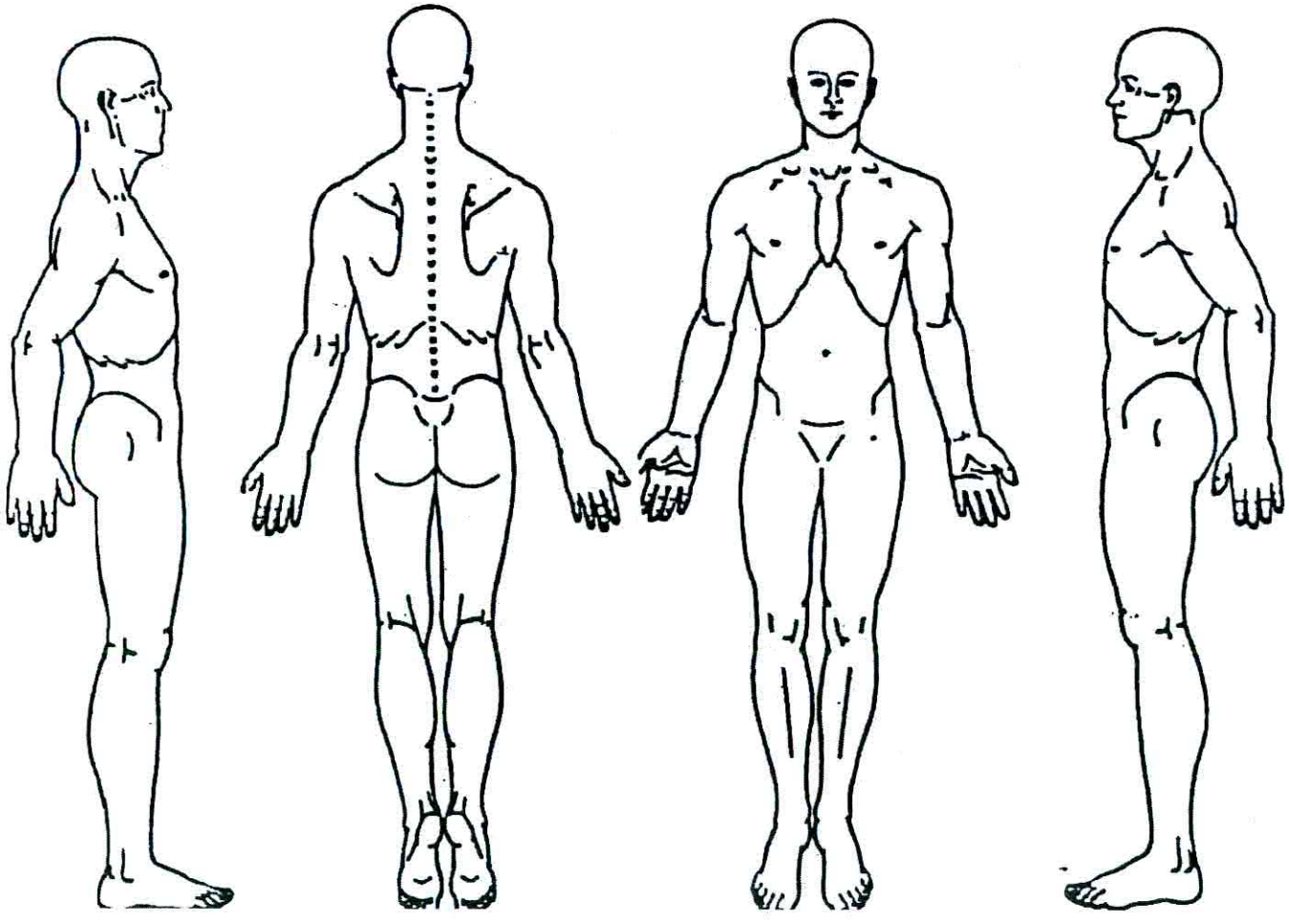
Pins and needles ooooo
ooooo

Burning xxxxx
xxxxx

Stabbing pain (Sharp) =====
=====

Aching pain (Dull) /////
/////





GREENAWALT CHIROPRACTIC POLICIES

Thank you for choosing us as your healthcare provider. The following are our financial and practice policies. If you have any questions or concerns, please do not hesitate to ask our staff.

All co pays and deductibles are due at the time of service. We accept cash, checks, Visa and MasterCard. We will submit an insurance claim on your behalf. **We do not bill any secondary insurance**. If your insurance changes, you must notify us immediately, and provide us with a copy of your new insurance card prior to your next appointment. If you fail to give us your current/correct insurance information you may be held responsible for the entire bill.

All new patients to our office must provide a copy of your Driver's License and Health Insurance Card.

We schedule appointments in an effort to minimize patient waiting time. However, the doctors treat each patient individually, and therefore you may have to occasionally wait past your scheduled time. If this is an issue please schedule your appointments on a day you have a more flexible schedule or early in the morning or right after lunch.

Cancellations or changes to appointments with less than a 24 hour notice will be subject to a $25.00 fee. **Initial**_____

Please read the following carefully:

As a courtesy to you, we will submit your claim to your primary insurance company, but please realize that your insurance is a contract between you, your employer, and the insurance company. We are not a party to the contract. Therefore if your insurance company refuses or ignores your claims, the balance is due by you. Any claim over six months from date of service is the responsibility of the patient and/or parent if patient is a minor.

Your co-payment is an estimate of the amount you are required to pay and is due at the time of your service. We are read disclaimers by your insurance company when we are given your insurance benefits, so you may have additional amounts due. Some chiropractic services are not covered by your insurance, it is your responsibility to know what your benefits are. Vitamins, supplements, bottled water, orthotics, initial evaluations, therapy, massage and/or x-rays may not be covered by your insurance plan. We will try to get the most accurate benefit information we can from your insurance company, however, if wrong information was given and the claim item is denied, you are ultimately responsible for the bill.

Insurance companies are now pending all claims, stating that they are waiting for information from the patient. In these cases the insurance company is trying to find out if someone else could be responsible for your service such as a third party relating to an accident, or they are looking to see if you or your spouse may have additional insurance plans. In either case, this information needs to be returned immediately to your insurance company. If your claim continues to be denied, you will be sent a statement for payment in full.

HMO/PPO/MC, all may require a referral from your primary care physician before your insurance will cover your services. Your insurance may require special forms be completed specific to your particular plan, and your insurance may require prior authorization. We are NOT an HMO provider on any insurance plans. We are a PPO provider on many plans, but it is your responsibility to know if you need a referral or authorization prior to services. **Initial** _____

FEES Returned checks will be subject to a $25.00 fee. Any account with a past due balance may be sent to collections. A collection fee of 40% will be added to your account balance when it is placed in collections with the collection agency. The balance of your account including this collection fee is due by you. **Initial** _____

By signing below you agree to the following: Authorization to use this form on all insurance submissions. Authorize release of information to insurance companies to get your account paid. Authorize and assign direct payment to Greenawalt Chiropractic . And you Authorize a copy of this to be used in place of original.
I have read the financial policy described above, I understand and agree to all provisions contained within.

_____ _____

Patient Signature (Parent signature in place of minor) Date

GREENAWALT CHIROPRACTIC
PERSONAL INJURY POLICIES

We thank you for choosing Greenawalt Chiropractic for your care following your personal injury. Please read the policies of our practice, if you have any questions please do not hesitate to talk to the office manager or biller.

We no longer accept any slip and fall personal injuries where a third party is involved.

We do not accept any third party payments. If you do not have Med Pay and you are not represented by an attorney and with a signed Medical Lien, then the only way we can treat you here is if you pay cash at time of service.

We do accept personal injury auto accidents with the following restrictions:

If you are involved in an auto accident in which the other vehicle's driver was at fault and/or cited, we will bill your Med Pay on your automobile policy for payment. If your policy is exhausted, your remaining balance will be applied to your attorney Medical Lien. You may also pay cash as you go. Medical Lien must be signed, so that we have it on file.

If you are involved in an auto accident in which the other driver was at fault and/or cited but, do not carry Med Pay on your auto policy we will include your chiropractic services on a Medical Lien with an attorney.

If you are involved in an auto accident in which you are at fault and/or cited, we will bill your Med Pay.

We will NOT bill your Group Health insurance for any services for a personal auto injury. If you have an attorney in which we have a signed Medical Lien and he instructs us to bill your Group Health insurance, we will present to him this signed policy showing that you agree to the terms not to bill Group Health. ***Initial*** _____

Your account is your financial responsibility. If you discontinue treatment here, you are responsible to keep us informed as to the progression of your personal injury case and inform us as to payments.

You agree to have all payments made directly to Greenawalt Chiropractic for all services rendered here.

You agree that if you discontinue with your attorney's services , your account balance will be due in full.

You agree to cooperate with our billing staff, your attorney and or your auto insurance to get your bill paid. In the event that your attorney and/or insurance company informs us you have discontinued their services or directed them not to pay Greenawalt Chiropractic , your account may be turned over to collections and incur additional collection, service and interest fees.

By signing below you acknowledge and agree to the policy and restrictions at Greenawalt Chiropractic as listed above.

_____ _____

Signature Date

Greenawalt Chiropractic
7500 West Sahara Avenue
Las Vegas, NV 89117
702/363-8989

ASSIGNMENT OF BENEFITS AND PAYMENT AGREEMENT

THIS AGREEMENT is made and entered into by and between _____ (referred herein as "patient") and Dr. Ronald Greenawalt and/or Dr. Timothy Dutt, and/or Dr. Paul S. Green, and/or any therapist treating at our chiropractic office referred herein as Greenawalt Chiropractic. WHEREAS patient desires to receive services from Greenawalt Chiropractic and therefore desires to assign certain rights and benefits to Greenawalt Chiropractic it is hereby agreed:

a. Patient assigns to Greenawalt Chiropractic any and all benefits payable by patients insurance or health care plan(s) as a result of charges incurred by patient for services rendered by Greenawalt Chiropractic. Patient also assigns to Greenawalt Chiropractic any and all contractual rights patient has against any insurance company, health care benefit plan, or any other party contractually liable to patient for payment of health care costs incurred by patient as a result of services rendered by this chiropractic office. This assignment of benefits and contractual rights relating to those benefits includes, but is not limited to the following described policies or plans. This agreement nullifies any agreement now or in the future for any third party (attorneys) other than Greenawalt Chiropractic to receive any payments for any insurance benefits including Personal Injury Protection or Med Pay for medical services provided and billed from this office. This is the financial agreement of patient and this chiropractic office to have directly sent to Greenawalt Chiropractic as addressed above.
b. Patient hereby directs all insurers and other persons responsible for patient's health care costs to make all payments for health care services rendered by this chiropractic office directly to Greenawalt Chiropractic.
c. Patient agrees that in the event patient receives any check, draft, or other payment subject to this Agreement, such monies will be held in trust for Greenawalt Chiropractic. Patient will immediately deliver said check, draft, or payment to Greenawalt Chiropractic. Greenawalt Chiropractic agrees to apply the proceeds from said check, draft or payments to patients debt for services rendered. Any violation of this agreement will at Greenawalt Chiropractic's election terminate patient charge privileges with Greenawalt Chiropractic and bring any balance owed by patient to Greenawalt Chiropractic immediately due and payable.
d. The assignment of benefits and contractual rights shall not exceed the total amount due Greenawalt Chiropractic for service rendered by this chiropractic office. Patient agrees that payment for services rendered by Greenawalt Chiropractic is due upon receipt of said services and acceptance of patient's assignment of benefits is a convenience to patient and that Greenawalt Chiropractic may revoke this assignment at any time.

e. Patient agrees to waive any applicable statute of limitation which may at any time interfere with Greenawalt Chiropractic right to collect for services rendered by Greenawalt Chiropractic to patient.
f. Patient hereby authorizes Greenawalt Chiropractic to release and permit the examination and/or copying of any of patient's medical records, x-rays, laboratory reports and the results of all test of any time or character to such persons as Greenawalt Chiropractic deems appropriate.
g. Greenawalt Chiropractic is authorized to submit a copy of this Assignment, or notice thereof, with the initial claim form(s) or any claim thereafter which Greenawalt Chiropractic submits to third party payor(s) as notice to the third party payor(s) of the assignment and other agreements contained herein. A copy of this document shall be as binding as the document bearing original signatures. At the time each claim is submitted, a copy of the claim will be stores for safekeeping in patient's file.
h. In the event that any section or provision of this Agreement is legally void, invalid, or unenforceable, all other sections and provisions of this Agreement shall remain in full force and effect.
i. The assignments and agreements contained in this document may not be revoked by patient without the express consent of Greenawalt Chiropractic.
j. Your chosen insurance company does not guarantee benefits until claim arrives; and at that time an Explanation of Benefits will be given by your chosen insurance company stating your exact benefits. Any billing to insurance that is not covered (paid) is patient responsibility.
k. PATIENT UNDERSTANDS THAT PATIENT IS FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED BY GREENAWALT CHIROPRACTIC. ANY LEGAL OR COLLECTION EXPENSES INCURRED BY THIS OFFICE TO COLLECT BALANCE OWED BY PATIENT WILL BE THE FINANCIAL RESPONSIBILITY OF SAID PATIENT.

_____ _____

Patient's signature Date

_____ _____

Witness Date