Berning Chiropractic
Dr. Jerry Berning D.C.
1316 East 11th
Hutchinson, Ks. 67501
Phone (620) 669-0128
Fax (620) 669-0268

Welcome

"The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet, and in cause and prevention of disease."
– **Thomas Edison**

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help. *Ask Joanie.*

Name:____
(First) (Middle) (Last) (Maiden)

Address:______________________ **City:**________________ **State:**_______ **Zip:**_________

Home Phone #:(_____) _________-_________ **Work Phone #:**(_____) _________-_________

E-mail Address: ____

I give Dr. Berning and his office staff permission to *phone* me in the following manner(s):(*check all that apply*)

Home telephone
❑ O.K. to leave message with detailed information on answering machine or with family member.
❑ Leave message with call back # only.

Work telephone
❑ O.K. to leave message with detailed information on voice mail
❑ Leave message with call back # only.

Cell phone # (______**)** ________-_________
❑ O.K. to leave message with detailed information on voice mail.
❑ Leave message with call back # only.

Date of Birth: ______/______/______ **Sex: (circle) Male / Female**

S/S #: ______/______/______ **Marital Status:** Minor Single Married Divorced Widowed

Your Employer:________________________ **Occupation:**________________________

Business Address:____________________ **City:**____________ **State:**_____ **Zip:**_________

❑Spouse's *or* ❑Parent's Name:______________________ **Workplace:**________________
(✓ the one that applies)

Whom may we thank for referring you to us?_________________________________

In case of emergency, contact __________________ **Phone**______________ **Relationship**___________

I give ______________________ **permission to access:** **❑Account Information** **❑Patient Health Information**
(Other than spouse)

Responsible Party (complete if different than above) **❑ Ins. Card Copied**

Name:______________________________ **Relationship to patient:**______________________

Address:_____________________ **City:**________________ **State:**__________ **Zip:**____________

D.O.B._____/_____/_____ **S.S. #** _______/_______/_______ **Employer:**______________________

Please turn over and complete

Health History

Name: ______________________ Date: ____________

☑ Check **all *existing*** and ***previous*** health conditions:

- ❑ Aids/HIV
- ❑ Allergy shots
- ❑ Anemia
- ❑ Anorexia
- ❑ Arm problems
- ❑ Asthma
- ❑ Arthritis
- ❑ Bronchitis
- ❑ Broken bones
- ❑ Cancer
- ❑ Convulsions
- ❑ Depression
- ❑ Diabetes
- ❑ Dizziness
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting
- ❑ Gout
- ❑ Headaches
- ❑ Hernia
- ❑ Herniated disc
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Insomnia
- ❑ Jaw pain
- ❑ Kidney disease
- ❑ Leg problems
- ❑ Liver disease
- ❑ Loss of feeling
- ❑ Low back pain
- ❑ Mid back pain
- ❑ Migraine headaches
- ❑ Miscarriage
- ❑ Multiple Sclerosis
- ❑ Muscle jerking
- ❑ Neck pain
- ❑ Numbness
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Polio
- ❑ Painful joints
- ❑ Parkinson's disease
- ❑ Pneumonia
- ❑ Prosthesis
- ❑ Pain between shoulders
- ❑ Ulcers
- ❑ Rheumatoid Arthritis
- ❑ Shoulder pain
- ❑ Sore muscles
- ❑ Stiff joints
- ❑ Thyroid problems
- ❑ Tuberculosis
- ❑ Tumors, growths
- ❑ Walking problems
- ❑ Weak muscles
- ❑ Other ____________________

Have you *ever* had chiropractic care before? ❑ **Yes** ❑ **No**

Dr.________________ **Last treatment**____________ **Where?**________________

Date last seen by your M.D./D.O. :____/____/____ **Doctors name**______________________

Surgeries and Dates:

- ❑ Aortic aneurysm ___/___/___
- ❑ Appendectomy ___/___/___
- ❑ Gall Bladder ___/___/___
- ❑ Heart Bypass ___/___/___
- ❑ Heart Stents ___/___/___
- ❑ Hernia ___/___/___
- ❑ Hip Replacement ___/___/___
  - ❑ Left ❑ Right
- ❑ Hysterectomy ___/___/___
- ❑ Knee Repair ___/___/___
- ❑ Knee Replacement ___/___/___
  - ❑ Left ❑ Right
- ❑ Mastectomy ___/___/___
  - ❑ Left ❑ Right ❑ Both
  - Reconstruction? ❑ Yes ❑ No
- ❑ Caesarean (C-section) ______________________
- ❑ Shoulder Surgery ___/___/___
  - ❑ Left ❑ Right
- ❑ Spinal Surgery ___/___/___
  - ❑ Neck ____________
  - ❑ Mid Back ____________
  - ❑ Low Back ____________
- ❑ Tonsillectomy ___/___/___
- ❑ Others ______________________________

Please list ALL Medication and Vitamins you are currently taking and the dosage:________________

____

______________________________________ ❑ *Copy of list in file*

Allergies: ❑ penicillin ❑ out door________________ ❑ in door________________

____

****

Dr. Notes ______________________________________

____

______________________________ *Signature* ____________________

Dr. Jerry Berning D.C.

Name: ______________________ Age: __________ Date: ______________ File # ______________

Describe what is bothering you today ____

____

____

Started: # _____ days ago # _____ weeks ago # _______ months ago (date of onset *if know* ___/___/___)

Is this condition due to: ❑ Fall ❑ Slip ❑ Tripped ❑ Reason Unknown ❑ Other ____________

Type of Pain: (*circle all that apply*) Sharp Stabbing Burning Achy Dull Stiff & Sore Other: ____________

Pain/discomfort: ❑ Constant ❑ Comes & Goes Frequency ______________

Severity of pain: (*No Pain)* 0 1 2 3 4 5 6 7 8 9 10 (*Agonizing*) Getting: Better Worse Same

What makes it *better?* Ice Heat Rest Movement Stretching Pain Medicine Other: ____________

What makes it *worse?* Sitting Standing Walking Lying Down Sleep Overuse Other: ____________

Have you had any x-rays or MRI *?* ❑ Yes ❑ No Where? ________________ **When?** __________

Doctors seen for THIS condition: Date Seen: ____________

Dr. ______________ **MD DC DO Where:** ____________

Diagnosis: ____________ **Treatment:** ____________

How have you treated *yourself:*

❑ Rest ❑ Rubs ❑ Ice ❑ Heat __________

❑ Ibuprofen __________ **❑ Tylenol** __________

❑ Prescriptions __________ **❑ Other** __________

List daily activities limited *by this condition*: __________

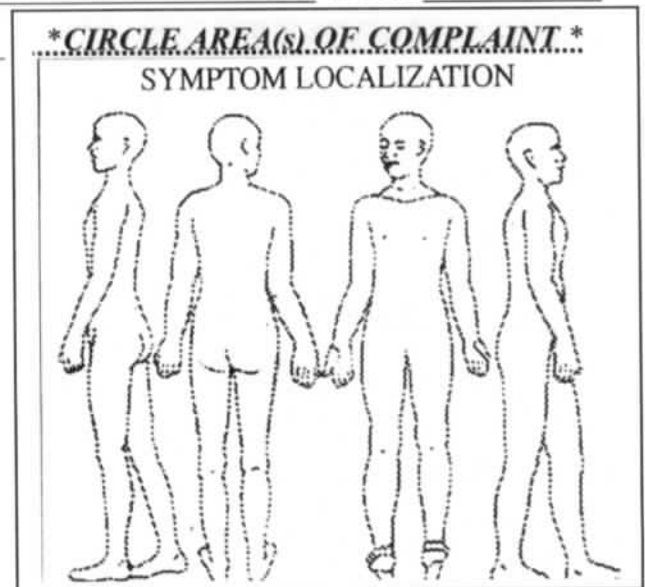
____

____

____

CIRCLE AREA(s) OF COMPLAINT

SYMPTOM LOCALIZATION



I understand this information and guarantee these forms were completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature X ________________________________ **Date** _____/_____/_____

❑Adult ❑Parent or Guardian ❑Spouse

FEMALES ONLY

Are you pregnant? (circle one) Yes No **Taking birth control?** (circle one) Yes No

X-ray confirmation: This is to confirm that you have been advised that x-rays can be hazardous to an unborn child. At this time, to the best of your knowledge, **I am not pregnant, *and I consent to spinal x-rays if deemed necessary.***

Signature of Patient: ______________________________ Date: _____/_____/_____

First Day of Last Period Date: _____/_____/_____

Signature of Parent/Guardian: ______________________________ Date: _____/_____/_____

~~Non Medicare Patient's~~
Berning Chiropractic
Dr. Jerry Berning

Signature on File / Authorization

Patient Name:____ ***Account #***________________

I hereby authorize *"Berning Chiropractic, or Jerry Berning D.C."* to release medical and billing information necessary to submit my claims for any treatment or services to my, then, current insurance company listed on my patient records. I also agree to provide complete current insurance coverage information in a timely manner for services provided to me.
I hereby authorize and request payment of medical / chiropractic benefits paid by my then current health insurance carrier, for services provided to me by "*Berning Chiropractic, or Jerry Berning D.C."* to be made directly to them. I understand and agree that health and insurance policies are an agreement between an insurance carrier and myself and all services rendered to me are charged directly to me and I am personally responsible for payment. I understand Berning Chiropractic will prepare reports and forms to assist me in collection from my insurance company.

X____ __________________
PATIENT (OR GUARDIAN IF MINOR) SIGNATURE DATE

INFORMED CONSENT CLAUSE

Even though Chiropractic is considered to be a safe form of healing art there is a remote chance for adverse effects to occur either temporarily or permanently. If you have any concerns about this statement or the possibilities of adverse effects please ask Dr. Berning. *I have read and understand this clause and hereby authorize Dr. Berning and whomever he may designate as his assistants to administer treatment, physical examination, X-ray studies, chiropractic care, therapy, or any clinic services that he deems necessary in my care. If deemed necessary x-rays will be sent to Dr. Steven J. Gould, D.A.C.B.R for diagnostic/radiologic consultation.* This authorization applies to all services rendered by Berning Chiropractic until it is revoked, in writing by me or my legal representative.

X____ __________________
PATIENT'S SIGNATURE DATE

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and if I have any questions or concerns I will contact this office.

X____ __________________
PATIENT'S SIGNATURE DATE

Only if patient is under the age of 18 yrs

*I (we) being the parents, guardian or custodian of minor*____________________________*, do hereby authorize, request* Dr. Berning D.C./Berning Chiropractic and staff *to perform examinations, diagnostic x-rays, and treatment that in their judgment is deemed advisable or is required to minor child.*

X____ __________________

PARENT, GUARDIAN, OR CUSTODIAN SIGNATURE DATE

~~Medicare Patient's Only~~

Explanation of Non-covered *Medicare* Chiropractic Services

Berning Chiropractic Center

Deductible:
Medicare requires you to pay a yearly deductible of $147.00 toward your medical expenses. (*If you have already been treated by other doctors this year that will be applied toward your yearly deductible also.)* If you have a secondary insurance it might pay the Medicare Deductible.

What Medicare will pay for:
After you have met your deductible, Medicare will pay 80% for "allowable treatment charges." care under an active treatment plan.
(The only "allowable treatment charges" for chiropractic is *Manual Manipulation of the spine.*)

Maintenance care: Medicare WILL NOT PAY for chiropractic maintenance therapy. *(care not under a treatment/corrective care plan.)* Maintenance is considered to be not medically necessary under the Medicare Policy Manual, chapter15, 240.1.3.A and payment for maintenance services would be your responsibility.
WE WILL ALWAYS TELL YOU IF THIS IS THE CASE.

Examinations:
In order to determine the extent of your condition, as well as the type of treatment you need, the doctor will perform an exam. Medicare WILL NOT PAY for this and the full payment must be made by you.

X-rays:
Medicare WILL NOT PAY for x-rays, however on your initial visit and possible during your treatment the doctor will want x-rays taken and payment must be made by you.

Physical therapy, supplements, and supports:
During the course of your treatment in this office, the doctor may determine that certain therapy, vitamin and/or supports may be necessary to assist in the treatment of your condition. Medicare WILL NOT PAY for these services and payment must be made by you.

I understand that although the chiropractic services listed above may be required for treatment of my condition, some charges are NOT covered by Medicare and I will be personally responsible for payment of these charges.

X______________________________ __________________________

Patient's Signature Date

~~Medicare Patient's Only~~

Berning Chiropractic
Dr. Jerry Berning D.C.

Medicare One Time Authorization / Signature on File

Patient Name: ________________________________ ***Medicare #*** ____________

I request the payment of authorized **Medicare** benefits be made on my behalf to:
"Berning Chiropractic, or Jerry Berning D.C." for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If **"other health insurance"** is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown.

X________________________________ ____________________
PATIENT'S SIGNATURE DATE

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X________________________________ ____________________
PATIENT'S SIGNATURE DATE

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