



CUPP CHIROPRACTIC CLINIC

DR. REE ANN CUPP



Instructions for new patient paperwork

1. Call our office or send us an email request to set up an appointment time.
2. Print out the following paperwork.
3. Fill out as completely as possible. If you have any questions, feel free to call our office at 504-888-1185.
4. Be sure to bring the following items with you to your appointment:
 - Photo ID
 - Insurance ID Card
 - Completed Paperwork

We would like to take this opportunity to thank you for choosing our practice for your chiropractic care.



CUPP CHIROPRACTIC

PATIENT RECORD

OFFICE USE ONLY	
DATE:	_____
FILE #:	_____

Name: _____ Home Phone: _____ Cell Phone: _____

Street: _____ Work Phone: _____

City: _____ State: _____ Zip: _____

Age: _____ Date of Birth ____/____/____ Social Security Number: _____

Employer: _____ Occupation: _____

Marital Status (Check) Married Widowed Separated Divorced How Many Children? _____

Spouse's Name: _____ Work Phone: _____

Employer: _____ Occupation: _____

Other Nearest Relative: _____ Phone: _____

List present complaints and duration:

1. _____
2. _____
3. _____

Remarks: _____

Please mark your areas of pain on the figures below.

Referred by: Friend _____ Phone Book Sign Mailer Other _____

Insurance Company: _____

Type of Coverage: Group Health Worker's Comp Personal Injury (Auto Acc.) Other _____

If you are covered under your spouse, please give spouse's Social Security Number: _____ Date of Birth ____/____/____

I understand and agree to authorize Dr. Ree Ann Cupp and all employees to administer whatever examination procedures and treatment as they deem necessary.

Patient's Signature: _____ Date _____

Parent, Guardian or Spouse's Signature Authorizing Care: _____ Date _____

PERSONAL & FAMILY HISTORY

PERSONAL	YES	WHEN	YES	FAMILY (SPECIFIC MEMBER)
ABDOMINAL BLEEDING				
ALLERGIES				
ANEMIA				
ARTHRITIS				
ASTHMA / EMPHYSEMA				
BACK DISORDERS				
BED WETTING				
BLACK TARRY STOOLS				
BLEEDING DISEASES				
BLOOD IN STOOL				
BLOOD IN URINE				
CANCER				
CHANGE IN BOWEL HABITS				
CHEST PAIN				
COLITIS				
CONSTIPATION				
COUGH				
COUGHING BLOOD				
DEPRESSION				
DIABETES				
DIAHRREA				
DIFFICULTY SWALLOWING				
DIZZINESS				
ENLARGED HEART				
DOUBLE VISION				
EPILEPSY				
FAINTING SPELLS				
GALLSTONES				
GALL BLADDER DISORDER				
GLAUCOMA				
HEADACHES				
HEART DISEASE				
HEART MURMUR				
HEPATITIS				
HOARSENESS				
HIGH BLOOD PRESSURE				
INDIGESTION				
IRREGULAR HEART BEAT				
KIDNEY INFECTION				
KIDNEY STONE				
LEG PAIN				
LUNG DISEASE				
LYME DISEASE				
NOSEBLEED				
NERVOUS DISORDER				
PAINFUL URINATION				
PARALYSIS				
PHLEBITIS				
PLEURISY				
PNEUMONIA				
PUS IN URINE				
RHEUMATIC FEVER				
STROKE				
SWELLING OF FEET				
SWOLLEN / PAINFUL JOINTS				
T.B.				
THYROID DISEASE				
ULCER				
VENERAL DISEASE				
VOMITED BLOOD				
OTHER				

SIGNED: _____ **DATE:** _____

Name _____ Date _____

PERSONAL HABITS

Please answer honestly. This information is needed to assure the best possible treatment. All information is confidential.
Please rate your answer on a scale of 1 to 5 (1 = No/Never, 5 = Yes/Often).

	1	2	3	4	5	ELABORATE
Exercise Regularly (3 to 4 x Week)						
Wear Seat Belts						
Use Illegal Drugs						
Drink Alcohol						
Smoke						
Chew or Dip Tobacco						
Experience Stress						
Other						

WOMEN ONLY

Menstrual Periods: Age of Onset _____ Regular? _____ Date Last Period Began _____

Age Menopause _____ Difficulty with Periods? Yes No Specify _____

Number of Children: Born Alive _____ Caesarean _____ Premature _____ Stillborn _____ Miscarriages _____

Describe Complications: _____

Have you ever been referred to a specialist? Yes (Please Elaborate) No

Have you ever been in an accident? Yes (Please Elaborate) No

Are there any environmental risks involved in your job or home environment? Yes (Please Elaborate) No

MILITARY SERVICE

Which branch of service did you serve in? _____ Length of enlistment? _____ From _____ To _____

Did you sustain any injuries? Yes (Please Elaborate) No



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Patient Disclosures and Authorizations

Please read the following information and initial in the appropriate sections.

Insurance Coverage

Welcome to Cupp Chiropractic Clinic. We will be more than happy to submit all insurance forms for you and help you recover the most from your benefits. Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the policy holder to pay co-insurance, co-payment and/or a deductible. If we are a participating provider for your specific insurance company, then we will abide by our contract fees, which include your co pay and/or deductible responsibility. Our clinic will call your insurer to verify your benefits; however, we are not responsible for your insurer's final payment and benefit determinations.

I understand and agree that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any and all fees for professional services rendered to me will be immediately due and payable.

Patient Initials _____

Assignment of Benefits

I hereby authorize my insurance company and/or any third party payee to direct any payment to Cupp Chiropractic Clinic for services rendered to me. If my current policy prohibits direct payment to the Doctor, then I hereby instruct and direct my insurance company and/or third party payee to make out the check to me and mail it as follows:

C/O: Cupp Chiropractic Clinic
3544 West Esplanade Ave.
Suite 1
Metairie, LA 70002

Furthermore, if I have an attorney representing me in this case, I authorize him/her to direct payment to you out of the proceeds of any settlement of my case.

I also grant you the right to request from my insurance company, attorney, and/or third party payee any information regarding the status of my claim and/or information on any payments made for my treatment at this clinic.

Patient Initials _____

Missed Appointments

It is the policy of Cupp Chiropractic Clinic to assess a **\$15.00** missed visit fee to patients who cancel appointments with less than a 24-hour notice. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others.

Patient Initials _____

Payment for Services

It is the policy of Cupp Chiropractic Clinic to have our patients make any and all payments due on their account upon arrival unless otherwise agreed upon.

Patient Initials _____

Consent for Use or Disclosure of Health Information

Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us give you this disclosure, please understand that we have and always will, respect the privacy of your health care information.

Medical Release

There are several circumstances in which we may have to use or disclose your health care information:

- ~ To another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- ~ To another party if they are potentially responsible for the payment of your services.
- ~ To an insurance company, adjuster or attorney in order to process any claims for reimbursement of charges incurred by me.
- ~ Within our practice for quality control or other operational services such as sending the following products to you: Appointment reminders, Birthday cards, Newsletters, Thank you cards, and any and all correspondence with Dr. Cupp. You have the right to refuse authorization to use or disclose your health information for mailings. It will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.
- ~ To the Chiropractic Association of Louisiana if we need the CAL's assistance to receive reimbursement for your services or because the party responsible for reimbursing your services has improperly processed your claim. By signing this form you are giving CAL authorization to re-disclose your information to the party responsible for the payment of your services, the CAL's legal counsel and state or federal agencies that may be asked to intercede on your behalf. You have the right to refuse authorization to use or disclose your health information to CAL. It will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions; however, if we agree with your restrictions, the restriction is binding.

Your Right to Revoke Your Authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health care information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by the person who receives the information and may no longer be protected by the federal privacy rules.

You may inspect or copy the information that we disclose at any time (§ 164.524).

This authorization will expire seven years after the date on which you last receive services from us.

I hereby authorize you to release any of my health information you deem appropriate in the manner described above.

Patient Initials _____

I understand that all health services rendered to me and charged to me are my personal financial responsibility.

I understand and agree to the conditions of this policy.

I have received a copy of this agreement. **Patient Initials** _____

Patient Name Printed

Patient Signature

Patient Account Number

Dr. Ree Ann Cupp D.C.
Authorized Provider Representative

Kristina Mercier
Personal Representative Signature

Date