

Si prefiere hablar espanol, favor de informarnos!

Welcome to our Chiropractic Office

Last Name: _____ First: _____ MI: _____

Birthdate : _____ SSN: _____ Married Single

Address: _____ City: _____ Zip: _____

Home phone: _____ Work: _____ ext. _____ Cell: _____

Occupation: _____ Employer: _____ Tel: _____

Do you prefer to be called on your home work cell phone

Email: _____ I check my email: daily weekly rarely

Check all the results you are seeking from care in our office:

<input type="checkbox"/> pain relief	<input type="checkbox"/> prevent future similar or worsening episodes
<input type="checkbox"/> improved activity ability	<input type="checkbox"/> improved posture, flexibility and strength
<input type="checkbox"/> slow aging changes in my spine	<input type="checkbox"/> relieve stress and tension
<input type="checkbox"/> better overall health	<input type="checkbox"/> unsure

How did you find us: another patient: _____ insurance referral
 our website signage my physician another chiropractor other: _____

I understand this office will protect my privacy and release only the minimum health information necessary to process my health care claims. I also understand that in all health care interventions, including chiropractic care, there are inherent risks. While chiropractic is extremely safe and the risk of any significant adverse effects is small, risks do exist. I do not wish the doctor to explain all potential risks to me, I wish the doctor to use his professional judgement to act in what he feels are my best interests. I understand I will have the opportunity to ask the doctor of any risks particular to my situation after he has become more familiar with my health status and has presented a treatment plan.

Signature: _____ Date: _____

New Condition Report

Name: _____ Has your address or insurance changed? Yes No

Date problem began _____ Gradual Episodes Chronic

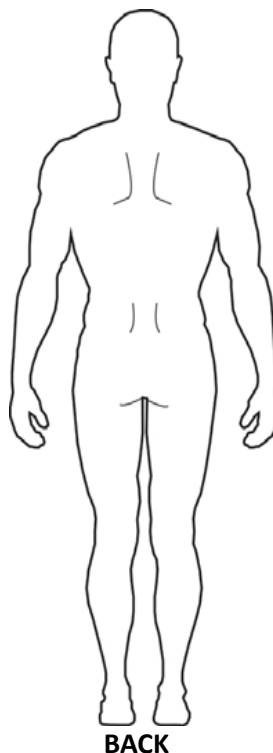
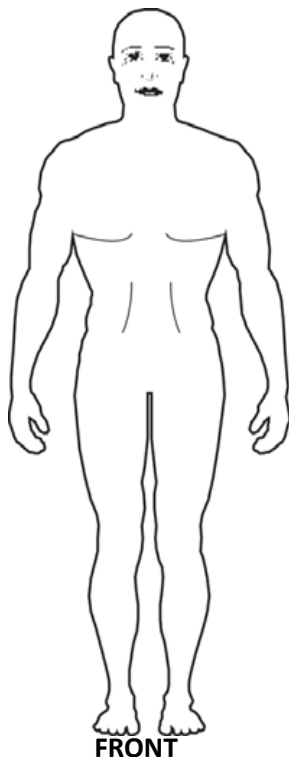
Is this Workers Comp Related Auto Accident Related Neither

Please describe your problem and tell us how you think it began:

Pain Level 1(low) • 2 • 3 4 5 6 7 8 9 10 (high)

How often are the symptoms present: Less than 25% 25-50% 50-75% 75-100%

Please mark the diagram where your symptoms are present:



Since your last update to our office have you had recent x-rays or other diagnostic tests: No Yes (describe)

Have any activities become difficult or impossible to perform? No Yes (describe)

Signature: _____ Date: _____

Financial Policies and General Information

If you HAVE HEALTH INSURANCE that covers our services we will attempt to collect fees directly from the responsible insurance company. It is important for you to provide correct, current and complete information to our office. If we are unable to verify insurance coverage on your initial visit, then we ask you to pay for that visit and we will adjust your bill accordingly after insurance is verified. After your benefits are verified, our office will ask you for an estimated co-payment at the time services are rendered. After the insurance has paid their portion your account will be updated and you will be billed for any remaining balance or provided a either choice of credit to your account or a return of the credit balance. Our efforts to collect directly from insurance companies are a courtesy on the part of our office staff. **Please remember that ultimately you, as the patient are responsible for paying for the services you are to receive.** Also, as policyholder, you may need to work with your insurance in order for claims to be processed fairly and completely.

If you DO NOT HAVE HEALTH INSURANCE that pays for chiropractic services you will be responsible for payment of services as they are rendered. If this is a hardship for you let us know. If possible we can grant credit to established patients. For your convenience we accept cash, personal checks, MasterCard, Visa and Discover. Our office offers discounted services when they are prepaid, please ask for details.

If you were INJURED ON THE JOB your services may be paid in full by worker's compensation. Until this treatment has been authorized by the worker's compensation carrier you are responsible for using your personal health insurance or by paying for services as they are rendered.

If you were injured in an AUTOMOBILE ACCIDENT your treatment may be paid either by your health insurance, by your automobile insurance, by a third party auto insurance or by your attorney. Policies vary so please consult with the office staff regarding insurance and the facts of the accident. Be aware that before treatment is rendered on a "lien basis" we must obtain full co-operation of your attorney by having him sign and return the lien. Once you have completed care, if settlement is not reached in **90 days**, we ask that you make regular payments of at least \$100/month towards your balance. A payment schedule can be created upon request.

If you are using MEDICARE, be aware that Medicare pays 80% only for the "spinal manipulation" portion of your visit. It does not pay at all for x-rays, examinations, physical therapy or supplies. Your secondary or "Medicare supplementary" policy may pay some or all of these fees, depending on the policy. If secondary does not cover all services, a copayment will apply.

At the discretion of the office/accounts manager, missed and canceled appointments without customary 24 hours notice may be charged to my account.

In the event collection efforts became necessary to collect overdue account, the patient will be responsible for the additional costs.

Signature: _____ Date: _____