

## New Patient Application

**Welcome to our Practice! Please thoroughly complete all questions. Thank you.**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Siblings: Yes No

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Parents Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Other: \_\_\_\_\_

Favorite hobbies or interests: \_\_\_\_\_

Child's Prior Doctor of Chiropractic: \_\_\_\_\_

City, State: \_\_\_\_\_ Approximate date of last Chiropractic treatment: \_\_\_\_\_

Chiropractic adjusting techniques you've had success with: \_\_\_\_\_

Pediatrician's name: \_\_\_\_\_

Phone: \_\_\_\_\_ City, State: \_\_\_\_\_

Please rate 1 (poor) to 10 (excellent) the quality of healthcare you feel you receive from your GP:

\_\_\_\_\_

Other Specialists you are currently under care with:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Method of payment for first visit

\_\_\_ Cash \_\_\_ Check \_\_\_ Credit Card

Person Responsible for payment:

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

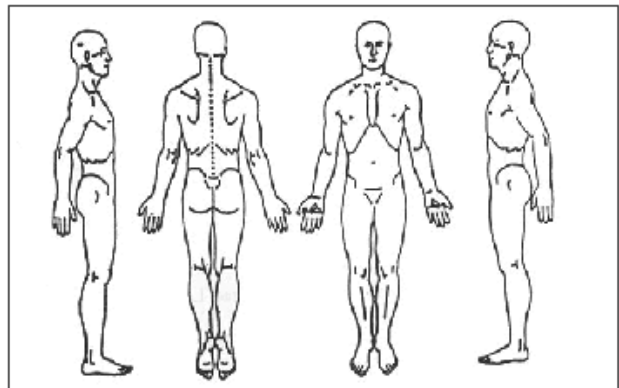
City: \_\_\_\_\_

State/Zip: \_\_\_\_\_

Do you have Health (crisis) Insurance? Y N

Insurance Company: \_\_\_\_\_

**Mark Area(s) of Health Concerns:**



Health reasons for consulting our office:

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

Has the child had the same or similar problem(s) before? \_\_\_ Yes \_\_\_ No

How long? \_\_\_\_\_ Please explain: \_\_\_\_\_

Does this condition interfere with: \_\_\_ school \_\_\_ sleep \_\_\_ daily routine  
Father/Mother/Brother/Sister, with similar problems?

Is this the result of an auto injury: \_\_\_\_\_ If so, when? \_\_\_\_\_

Other doctors who have treated this problem: \_\_\_\_\_

What treatments did your child receive: \_\_\_\_\_

Medication(s) your child currently takes: \_\_\_\_\_

Does your child take supplements? Yes or No If yes, please list \_\_\_\_\_

For Menstruating Female Patients. Is there any chance your child is pregnant? Yes \_\_\_ No \_\_\_

What do you understand chiropractic care to be? \_\_\_\_\_

Do you know what a subluxation is? Yes or No If yes, please describe: \_\_\_\_\_

Does your child play any sports or exercise regularly? Yes or No If yes please describe \_\_\_\_\_

Did the mother have an ultrasound during this pregnancy? \_\_\_\_\_ Frequency \_\_\_\_\_

Place of Birth: Home / Birth Center / Hospital \_\_\_\_\_ Type of Birth: Vaginal / C-section

Was anesthesia used? \_\_\_ Spinal \_\_\_ Epidural \_\_\_ Other Was Labor induced? Y / N Why: \_\_\_\_\_

What position was the child delivered: Squatting / On Back

Birth Trauma: Doctor assisted – twisting, pulling Vacuum Extraction / Forceps

Newborn Trauma (medical procedures and tests): \_\_\_\_\_

Did your child breast-feed? Y N How Long \_\_\_\_\_

Please describe any injuries, falls or traumas: \_\_\_\_\_

Do you or have you had any of the following? Please write *C* of current and *P* for Past

\_\_\_ Angina \_\_\_ Arthritis \_\_\_ Asthma \_\_\_ Allergies \_\_\_ Bed wetting \_\_\_ Cancer \_\_\_ Colic \_\_\_ Colds \_\_\_ Diabetes \_\_\_ Ear infections

\_\_\_ "Growing pains" \_\_\_ Headaches \_\_\_ Heart Disease \_\_\_ Kidney Disease \_\_\_ Learning disorders \_\_\_ Migraines

\_\_\_ Numbness/tingling \_\_\_ Sciatica \_\_\_ Seizures \_\_\_ Sinus Problems \_\_\_ Spinal curvature \_\_\_ Stroke \_\_\_ Thyroid disorder \_\_\_ Ulcers

Other Medical diagnoses or anything else you are concerned about: \_\_\_\_\_

*The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.*

Parent or Guardian Signature: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

*We believe that a clear definition of our policies will allow us both to concentrate on the big issue of regaining and maintaining your health...*

**APPOINTMENT POICY**

*In order to serve all our patients we ask that you call if you are unable to make your appointment. If you find yourself running late, please stop by the office and notify the receptionist and we will get you in for your visit as soon as possible. When you fail to notify our office, this leaves a time slot open that could otherwise be used to help someone else. Please help us help others. – Thank you*

**Payment Schedule**

You have taken the first step on the path to optimal vibrant health. We take pride in delivering the finest in chiropractic care. The following payment options are available to help you handle your financial obligations.

- **Plan # 1 – CASH**  
Payment is due at the time of service, unless other payment arrangements have been made by the office.
- **Plan #2 – INSURANCE**  
Please present your insurance card today. We will call your insurance company for you to verify your coverage. If you have coverage for your chiropractic care, our office will submit claims for you. After your insurance company has been reached for benefit information a financial payment plan will be presented on your following visit. Until we have the completed necessary insurance information, you will be required to pay for your care on a cash basis.
- **Plan #3 – PERSONAL INJURY**  
You need to provide us with the accident report, your auto insurance, health insurance, and attorney if applicable. If the claim is a possible their party liability, please provide us with the other parties' insurance carrier information. Although my insurance or lawsuit may eventually pay for services rendered, if insurance or lawsuit does not pay, I understand that I am responsible to pay my balance in full.

**Assignment of Benefits**

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between the provider and patient. Our policy requires payment in full for all services render at the time of visit, unless other arrangements have been made with the office. If all charges are not paid when due, the undersigned agrees to pay cost of collections. This includes 33 1/3% attorney's fee or other collection agency fees, plus interest at the rate currently applicable by Virginia statue to judgments. It is agreed that any legal action for collections of monies due may be properly instituted in the courts of Virginia and Virginia Law shall apply.

**I QUALIFY AND UNDERSTAND THE REQUIRMENTS OF PLAN(s) # \_\_\_\_\_.**

**Patient's or Guardians Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

Please Print Patient Name: \_\_\_\_\_ CA Initials: \_\_\_\_\_

**Patient Authorization regarding chiropractic care provided in an “open adjusting” environment**

It is the practice of this office to provide chiropractic care in an “open adjusting” environment. “Open adjusting” involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care care discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal-law with respect to what is known as an “incidental disclosures” of health information. It is our view that the kinds of matters related in an “open adjusting” environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on your care from our office or on your relationship with our staff.

Your signature indicates you authorization of this activity.

\_\_\_\_\_  
Name (Printed) Signature Date

**Cancellation/No-Show Policy for Massage Therapy/Muscle Work**

It is the policy of this office that if you find it necessary to cancel or change an appointment you must allow at least 24 hours prior notice. Missed and canceled appointments without proper notification will result in a \$30.00 cancellation fee.

If you are late for an appointment, it is necessary to still end at the appointed hour, so not to effect the appointment following you.

\_\_\_\_\_  
Signature Date

**Authorization for care of a Minor**

I herby authorize Dr(s). \_\_\_\_\_ to administer care as deemed necessary to my son/daughter

\_\_\_\_\_  
Name (Printed) Signature Date

Witnessed:\_\_\_\_\_

**This notice describes how chiropractic and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

In the course of your care as a patient at our office we may use or disclose personal and health related information about you in the following ways:

- Your personal health information including your clinical records, may be disclosed to another health provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing record may be disclosed to another party, such as an insurance carrier, an HMO or PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communication with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any changes in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to our office manager.

If you would like further information about our privacy poise and practices please contact our office manager.

This notice is effective as of \_\_\_\_\_. This notice and any alteration or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

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Name (Print)	Signature	Date
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If you are a minor, or if you are being represented by another party:

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Person Responsible (Print)	Signature	Date
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Description of the authority to act on behalf of the patient