Chiropractic Family Health Centre

Referred By: ______________________

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	ADDRESS		
CITY, STATE	ZIP	HOME PHONE	CELL PHONE
PATIENT DATE OF BIRTH	PATIENT SSN	SEX ❑ Male ❑ Female	MARITAL STATUS ❑ Single ❑ Married ❑ Other______
OCCUPATION	PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)	EMPLOYER PHONE	
EMAIL	REASON FOR YOUR VISIT		

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE	
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE
SECONDARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE	
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

PRIMARY DOCTOR/FAMILY DOCTOR	REFFERING DOCTOR	
IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE

Authorization to release health information to (family member, other health professional, attorney):

Name(s)	ADDRESS		
CITY, STATE	ZIP	HOME PHONE	DAYTIME PHONE

DATES OF SERVICE FROM: TO:	AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED) ❑ NEVER DATE:

Release the following information:

❑ **All Records** ❑ **Chart Notes** ❑ **Radiology Reports** ❑ **Operative Reports** ❑ **History & Physicals**

RELEASE OF INFORMATION

I understand that:

- once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- my records are protected and cannot be disclosed without written permission
- this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	EMAIL
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):	

Chiropractic Family Health Centre

Date: ______________________

PATIENT MEDICAL HISTORY

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)

SYMPTOMS BEGAN ON:

Painful Activities
- ☐ NONE
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Bending
- ☐ Lying Down

How often?
- ☐ Constantly (76-100%)
- ☐ Frequently (51-75%)
- ☐ Occasionally (26-50%)
- ☐ Intermittently (0-25%)

Exercise
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

Work Activity
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

Is your condition worsening?
- ☐ Yes
- ☐ No

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation: ______________________ ☐ Retired ☐ Disabled (reason ______________________)

☐**Yes** ☐**No** - Do you drink alcohol? ☐ Daily ☐Weekly ☐Infrequently ☐ Recovering Alcoholic

☐**Yes** ☐**No** - Do you use tobacco? ☐ Smoke (___ packs per day) ☐ Chew

Injuries/Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following?

- ☐ NONE of the problems listed
- ☐ allergies
- ☐ anemia
- ☐ arthritis conditions
- ☐ asthma
- ☐ arterial fibrillation
- ☐ bleeding problems
- ☐ BPH
- ☐ CAD coronary artery disease
- ☐ cancer
- ☐ cardiac arrest
- ☐ celiac disease
- ☐ chest pain
- ☐ CHF congestive heart failure
- ☐ chronic fatigue syndrome
- ☐ depression
- ☐ diabetes
- ☐ drug/alcohol abuse
- ☐ erectile dysfunction
- ☐ fibromyalgia
- ☐ Gerd
- ☐ heart disease
- ☐ high cholesterol
- ☐ hyperinsulinemia
- ☐ hyperlipidemia
- ☐ hypertension
- ☐ hypogonadism male
- ☐ hypothyroidism
- ☐ infection problems
- ☐ insomnia
- ☐ irritable bowel syndrome
- ☐ kidney problems
- ☐ menopause
- ☐ migraines/headaches
- ☐ neuropathy
- ☐ onychomycosis
- ☐ organ injury
- ☐ osteoporosis
- ☐ pulmonary embolism/blood clot in legs
- ☐ seizure disorders
- ☐ shortness of breath
- ☐ sinus conditions
- ☐ stroke
- ☐ syndrome X
- ☐ tremors
- ☐ wheat allergy

Medications: List any medications you are currently taking (please include over the counter medications):

PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION	DOSAGE	PERSCRIBING DOCTOR

INFORMED CONSENT FOR TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including, but not limited to; a comprehensive exam, diagnostic x rays, various modes of physical therapy as well as nutritional and exercise recommendations by the licensed Doctors of Chiropractic at this office.

I understand that, as with any health procedure, there are certain conditions that may arise during a chiropractic adjustment. Those complications include but are not limited to: bruising, soft tissue swelling, fractures, dislocations, stroke, muscle strain, costovertebral sprains and separations. We screen our patients for indications that they are candidates for chiropractic adjustments to the best of our ability. I do not expect the Doctor(s) to anticipate all risks and complications during the course of my treatment, based on the facts known about my medical history.

I have had an opportunity to discuss with the Doctor the nature, purpose and risk of Chiropractic adjustments and other recommended procedures and have had all my questions answered to my satisfaction. I understand that the results are not guaranteed.

Massage:
Draping will be used by the therapist as required to expose only the areas of my body that require treatment and/or to my comfort level. I hereby request and consent to the performance of massage therapy by the licensed massage therapist at this office.

Acupuncture:
I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice. I understand that methods of treatment may include, but are not limited to, Chinese herbal medicine and nutritional counseling. The herbs may have an unpleasant smell or taste. I have been informed that acupuncture is generally safe, but it may have some side effects including; bruising, numbness, tingling near the needling sites that may last a few days, dizziness and/or fainting. I agree to the risks and benefits of acupuncture by the licensed Acupuncturist at this office.

I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risk(s) involved in undergoing treatment and I have decided that is in my best interest to undergo chiropractic, massage and/or acupuncture treatment. Having being informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment, and any and all health care providers who provide treatment at, or are associated with this office.

________________________________ ________________________________

Guardian/Patient's Name (Printed) **Guardian/Patient's Name (Signature)**

________________________________ ____/____/____ ________________

(if minor) Patient's Name (Printed) **DOB** **Date**

SCHEDULING & FINANCIAL POLICY

Dear Patients,

We are always striving for excellence in all aspects of our practice. We are committed to providing outstanding patient care as well as unmatched customer service. We are clarifying our office procedures for you, to help make your experience a better one. Please read the following and sign. If you have any questions about these procedures, please speak with your treating Doctor.

SCHEDULING:

1) All ***scheduled*** patients will receive priority. Walk-in patients may still be accepted, but only after all scheduled patients have been seen. This will be true regardless of arrival order.
2) As a courtesy to our patients, our office will provide an automated courtesy call or email 24 hours prior to your scheduled appointment. In an effort to stay consistent with your treatment plan, our office will call you to reschedule any missed appointments or unscheduled future appointments. If you are unable to keep your scheduled appointment for any reason, please contact our office at your earliest convenience to reschedule by calling (703)222-3737.
3) Missed appointments are subject to a $25 missed appointment fee in the event our office is not notified and/or the appointment is not rescheduled for a future date. We understand that extenuating circumstances may occur. In these instances, we will be happy to waive the fee on a case by case basis.

INSURANCE BILLING:

1) Your insurance policy is a contract between you and your insurance company. As a courtesy to you, we will call your insurance to verify benefits and coverage. **Please be aware that benefit verifications are not a guarantee of payment.** Additionally, as a service to you, we will bill your insurance for all visits. Claims will process based on the terms and conditions of your health plan contract. All deductibles, copayments/coinsurance, denied or rejected claims will be the patient's financial responsibility. It is your responsibility to provide our office with your insurance details, current address, and birthdate. Please present your insurance and driver's license to us on your first visit so we can bill your insurance completely and accurately.
2) All copayments, coinsurances and deductibles will be collected at the time service is rendered. A processing fee of $35 will be accessed for any returned checks.
3) Please note that you may be subject to interest if a balance is left unpaid for 90 days. In the event, your account is sent to our collections agency, it is your responsibility to pay any and all related costs including but not limited to collection agency fees, attorney fees and/or court fees assessed in the collection of my outstanding balance of 35% until fully paid. These fees also apply to Self-Pay patients paying out-of-pocket for services rendered if their balance exceeds 90 days.

PERSONAL INJURY BILLING:

1) **MEDPAY:** "Medical Payments" or "PIP" is part of your own auto insurance policy which will immediately cover the costs of your medical expenses given by a licensed health care provider and those of any passengers in your car, up to a certain limit, regardless of fault. If payment is made by this method and you are not at-fault your insurance premiums will not be increased, and you will not have to repay any benefits (Virginia Code § 38.2-1905). This will allow you to receive the treatment you need for your injuries and pay your medical bills without the delay of dealing with the other driver's third party insurance company.
2) **PERSONAL HEALTH INSURANCE:** The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts (often referred to as "MedPay") does not normally contain order of benefit determination provisions. As such, unless state law or regulation specifies otherwise, such coverage would be primary. MedPay coverage is not liability coverage and is not dependent upon fault. Per Virginia Code § 38.2-2201.D6, a

patient's medical expense benefits may not be reduced because of any benefits paid, payable or provided by any health insurance contract. Per Virginia Code § 8.01-27.5, if you choose to provide your health insurance coverage information to your treating health care office, the provider will submit your medical claims daily for reimbursement. In the event that you do want to utilize your health insurance benefits, you will be responsible for any and all deductibles, copayments and and/or coinsurances that are applied to each claim. Please note that you are not required to provide your health insurance coverage information to your health care provider if you wish to utilize your medical expense coverage only.

3) **LIABILITY INSURANCE:** Virginia is currently an "at fault" state regarding payment of claims resulting from an automobile accident or personal injury. This means the responsible party, or his or her insurance, should cover the cost of medically necessary treatment given by a licensed health care provider. Your personal health insurance, if applicable, is also billed consistently throughout treatment. When all treatment is complete and a final statement is provided by the Doctor, billing will proceed through the at-fault party carrier or through your attorney if one was attained.
4) A lien will be provided to you to review and sign. Per Virginia Code § 8.01-26, this lien will be sent to your auto insurance, attorney and at-fault liability carrier from our office to ensure all payments are made directly to our practice for services rendered to you throughout your treatment.

COSTS OF GOODS AND SERVICES:

1) Cash patients are financially responsible for the cost of all care including; adjustments, physical therapy, x-rays and exams, supplements, herbal products, supplies and equipment. These services and/or products are to be paid at the time of service. Special orders must be paid at the time the order is placed.

MASSAGE & ACUPUNCTURE:

1) All Massages and Acupuncture appointments are to be paid in full upon booking. **These are concierge services only and are not billable to your personal health insurance.** Notice of cancellation of a scheduled appointment must be given 24 hours prior to the session. We will apply your appointment deposit towards another session as long as it is redeemed within 30 calendar days of the original session. If the cancellation is made less than 24 hours to your appointment, you will be financially responsible for 50% of the scheduled session fee.

All financial and claim documents must be completed prior to the second visit or no treatment can be given.

I have read and understand the Scheduling/Financial Policy given to me by the Chiropractic Family Health Centre and Nova Health & Wellness. I understand that I am ultimately responsible for any services rendered to me by any and all licensed health care professionals at this office. Payment for services is not contingent upon my insurance coverage or settlement with a third party. I understand that if I terminate care outside of my doctor's recommendations, any balances will be due immediately.

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Guardian/Patient's Name, Printed

______________________________ ________________________

Guardian/Patient's Signature **Date**