FAMILY
CHIROPRACTIC & HEALTH CENTER, P.C.
28190 North Main Street, Suite A
Daphne, Al 36526

Date: _____
Whom may we thank for referring you?
_____

Name: _____ *Preferred Name:* _____
Last Name, First Name Middle Initial

Address: _____
Street and/or box # City State Zip

Preferred Phone: H / C / W _____ *Secondary:* H / C / W _____

D.O.B: _____ *Minor*: YES / NO *Sex:* MALE / FEMALE *Preferred Pronouns:* _____

Occupation: _____ *Employer:* _____

Employer Address: _____ *Employer Phone:* _____

Marital Status: MARRIED / SINGLE / WIDOWED / DIVORCED / SEPARATED / OTHER

Emergency Contact: _____ *Relationship:* _____

Emergency Contact Phone: _____
May we share medical information with this person? YES / NO

Do you have medical insurance? YES / NO *Do you have a secondary policy?* YES / NO

Primary Policy
Name of insured: _____ *Relationship to insured*: SELF / CHILD / SPOUSE

D.O.B. of insured: _____ *S.S.N.:* _____ *Insurance Company:* _____

Insurance I.D. #: _____ *Group #:* _____

Secondary Policy
Name of insured: _____ *Relationship to insured*: SELF / CHILD / SPOUSE

D.O.B. of insured: _____ *S.S.N.:* _____ *Insurance Company:* _____

Insurance I.D. #: _____ *Group #:* _____

I certify that the information on this form is correct, and I authorize the doctors to treat me. I understand that I am financially responsible for all charges and services rendered. If I am insured, I do herby authorize the release of information for completing and filing insurance claims, and I do authorize my insurance company to give direct payment to Family Chiropractic & Health Center, P.C. In the event it becomes necessary for Family Chiropractic to take legal action for the collection of said charges, I agree to pay all reasonable attorney's fees and collection expenses.

Signature: _____ *Date:* _____
Patient, Parent or Guardian

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Medical History

Primary Care Physician: _____ *Physician Phone:* _____
List all known allergies:

_____

List all current medications (including vitamins and supplements):

_____

_____

List all surgeries or hospitalizations:

_____

_____

List any past or current major illness[es] (cancer, heart disease, infections, etc.):

_____

_____

List any family history of major illness[es] (cancer, heart disease, infections, etc.):

_____

_____

Describe your chiropractic problem: _____

Have you ever received chiropractic care? YES / NO *By whom?* _____

Female patients only:

Are you currently pregnant? YES / NO *Date of last menstrual period:* _____

Accident Information
Is this condition due to an accident? YES / NO *Date of accident:* _____

If applicable:

Type of accident: Automobile / Work / Home / Other: _____

Have you made a report of the accident? YES / NO *To whom?* _____

Responsible parties: Auto Insurance / Worker's Compensation / Employer / Other: _____

I certify that the information on this form is correct to the best of my knowledge:

Signature: _____ *Date:* _____
Patient, Parent or Guardian

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Chiropractic Condition

Date current symptoms began: _____

These symptoms are: CONSTANT / FREQUENT / OCCASIONAL / INTERMITTENT

Please indicate your present pain level (circle one):

Do your symptoms affect your ability to get a good night's sleep or perform daily activities? YES / NO

For each item below circle the description that most closely describes your current condition:

1. *Sleep:*
   PERFECT SLEEP / MILDLY DISTURBED / MODERATELY DISTURBED / GREATLY DISTURBED / TOTALLY DISTURBED

2. *Personal Care (washing, dressing, etc.):*
   NO RESTRICTION / MILD RESTRICTION / MODERATE RESTRICTION / NEED SOME ASSISTANCE / FULLY ASSISTED

3. *Travel*
   LONG TRIPS: NO PAIN / LONG TRIPS: MODERATE PAIN / SHORT TRIPS: MODERATE PAIN / SHORT TRIPS: SEVERE PAIN

4. *Work*
   UNLIMITED CAPACITY / USUAL CAPACITY / HALF CAPACITY / MINIMUM CAPACITY / NO CAPACITY

5. *Exercise/Recreation:*
   NO RESTRICTION / MILD RESTRICTION / MILD RESTRICTION & SORENESS / CONSIDERABLE RESTRICTION / UNABLE

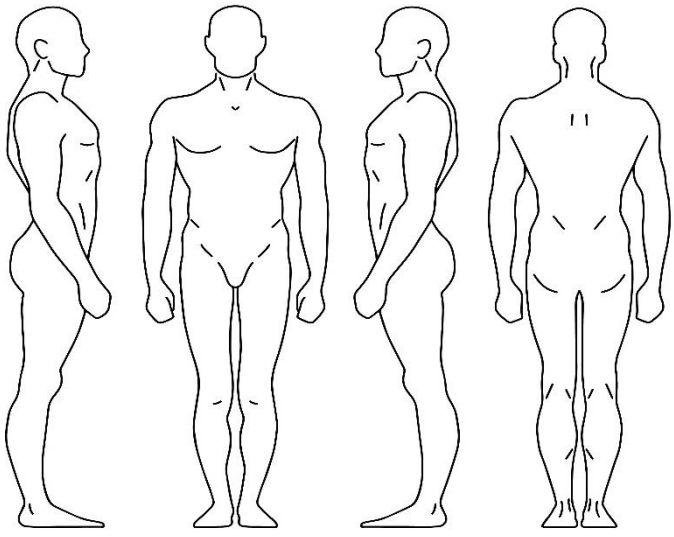
Is there anything that helps relieve your symptoms (circle all that apply)?

ICE / HEAT / MEDICATION / WALKING / STANDING / SITTING / LYING / REST

OTHER:_____

On the figures to the right, mark the area[s] of pain/symptom you have using the following symbols:

B – *Burning*, S – *Stabbing*, N – *Numbness*, T – *Tingling*, D – *Dull*, SH – *Sharp*, A – *Ache*, ST – *Stiffness*



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Financial Policy

Our practice financial policy

We are committed to providing you with the best possible care and service and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff. Unless either you or your health coverage carrier have made other arrangements in advance, full payment is due at the time of services. For your convenience, we accept Visa, MasterCard, Discover, American Express, CareCredit, cash and check. Please note that a 4% surcharge will be added to CREDIT CARD transactions.

Your insurance

We have made prior arrangements with many insurers and other health plans. We will bill those plans with which we have an agreement and will collect any required co-payment at the time services are rendered. If your health plan determines that a service will not be covered, you will be responsible for the complete charge. In that event, we will bill you and payment is due upon receipt of that statement.

If you have insurance coverage with a company by which we do not have a prior agreement, we will prepare and send the claim for you, as a courtesy. In this case, your insurer may send the payments directly to you; therefore, charges for your care and treatment are due at the time of service.

Minor patients

For all services rendered to minor patients, the adult accompanying them is responsible for payment. Children 14 years of age or younger should be accompanied by a parent or legal guardian for treatment.

Massages: insurance coverage and missed appointments

Family Chiropractic & Health Center, P.C. is unable to bill your insurance for massages. Effective January 2007 our office was notified that massage therapists are not recognized as medical providers. ***All monies for massage are due at the time of service.***

In order to provide the best possible service and availability to all our massage patients, it is our policy that you notify the clinic at least 24 hours prior to cancelation. Failure to cancel within these guidelines will result in full charge for the time missed.

By signing below, you are indicating that you have read and understand the financial policy of Family Chiropractic & Health Center, P.C. and agree to be bound by its terms. Also understanding and agreeing that such terms may be amended occasionally by Family Chiropractic & Health Center, P.C. and the clinic will notify patients if such changes are to occur:

Print name of patient: _____

Signature: _____ *Date:* _____

Patient or Responsible Party of Minor

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Patient Consent

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician, and it is the responsibility of the staff to carry out the instructions of such physician(s).

Initial: _____

Release of information

By acknowledging this form, you are granting consent to Family Chiropractic & Health Center, P.C. to use and disclose your protected health information for the purposes of treatment, payment and healthcare operations. Our notice of privacy practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at (251) 621-0700. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent that we have already used or disclosed your protected health information in reliance on your prior written consent.

Initial: _____

Medicare consent to release information

I certify that the information given by me in applying payment under Title XVII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare claims.

Initial: _____

Verification of non-pregnancy (female patients only)

By my acknowledgement of this form, I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time. In the event that I am pregnant, I have/will disclose this information to my physician.

Initial: _____

Print name of patient: _____

Signature: _____ Date: _____

Patient or Responsible Party of Minor

Witness: _____ Date: _____