Advanced Chiropractic Wellness Center, LLC. 20 South Anguilla Rd., 06379 Unit 4

Patient Name ______________________________ ______________________________ ____________________
First Last M.I.

Male ☐ Female ☐ Ethnicity:____________ Preferred Language: English or___________
Date of Birth: ______________ Age: ___

Street Address ____ Apartment: _________________________
City ____________________ State __________ Zip Code _____________
Home Phone: ____________________ Work Phone: _____________________ Mobile: ________________________ Email Address: ____ Occupation: ________________________________
Marital Status: Single☐ Married☐ Divorced☐ Widow☐ Widower ☐
Who may we thank for your referral? _______________________________ Primary Dr:_________________________
Have you been to a Chiropractor in the past? Primary Dr. Phone or town__________________

Emergency Contact or Health Care Proxy Information
Name: _________________________________ Relation:___________________
Phone number: _______________________

***Communication Preference (Circle):** HOME PHONE | CELL PHONE |WORK PHONE |EMAIL | EMERGENCY CONTACT |

Primary Insurance Carrier/ ID#:__________________________ Subscriber:__________________ DOB:____________
Secondary Insurance Carrier/ ID#:_________________________ Subscriber:__________________ DOB:____________

Draw where it hurts or where you have symptoms below

Backside *Frontside*

Describe your condition below

Main Complaint(s):

How & Where did it occur?

What makes it feel better?

What makes it worse?

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Was this complaint due to a work injury or automobile accident? *Yes | No*

***Severity of complaint*:** mild mild-moderate moderate moderate-severe severe

***Frequency of complaint*:** constant occasional intermittent frequent

Status: Improved, Slightly better, Unchanged, Slightly Worse , Worse, Exacerbation, New Problem

Quality: ache—burn--dull—exquisite--sharp—shooting—stabbing—stinging—throb—tingle—numb—

***Pain Scale*:** weak (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unimaginable pain)

Activities/Exercise you enjoy or presently do?

Describe your work do you do?

Have you had this condition before?

Medications?

Supplements are you taking?

Other or prior illnesses you have or had?

List any prior trauma(s)?

MRI, XRAY, CT SCAN, BLOODWORK results in the past year?

Any history of cancer or infections disease(s)?

Patient: ________________________ Adult signature:____________________ Date:_________

I

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Informed Consent

I/We hereby request and consent to the performance of Chiropractic related services at Advanced Chiropractic Wellness Center. Treatment may consist of a combination of manipulation, muscle work, traction, stretching, exercises, nutritional counseling, dry needling and examination. The exact nature of care will be determined by the doctor and myself. If I have any questions about such care it is my responsibility to ask the doctor to address my concerns prior treatment.

I understand that the practice of medicine, chiropractic care, or any form of health care is not an exact science and that my care may involve making clinical judgments based upon the information known to the doctor at the time of care. I am responsible for providing all health care providers (HCP) with accurate, current & relevant health information, including testing, medications, illness, past or future surgeries.

I also understand that it is not reasonable to expect the doctor to be able to anticipate or explain all possible risks and complications of care at each visit unless I specifically ask, and that an undesirable result does not necessarily indicative of malpractice. No guarantees regarding outcomes can be made by and I have no expectation of any.

I have been and or am presently advised that although the incidence of complications associated with chiropractic care is extremely low, ANYONE undergoing any sort of manipulative procedure, treatment, exam, exercises or home recommendations should know that potential hazards or complications can arise such as, but not limited to:(soreness, stiffness, strains, bone fracture, sprains, dislocations, infection, disk injury, nerve injury, stroke or even death in extreme and rare cases).It is for these reasons that the doctor may examine me, recommend x-rays, MRI, ultrasound, CT scan, laboratory testing, request health care records, etc.. I recognize that despite anyone's diligence and best efforts, there are some conditions and or physical aberrations that will remain unknown and undetected to the doctor. I understand that Chiropractic care is a specialty and is not a substitute for general medical or primary care.

I authorize Advanced Chiropractic Wellness Center, LLC., to obtain or send my medical information to or from other medical professionals/labs. I permit a copy of this authorization to be used in place of the original. I authorize this office to discuss with me or my designated proxy(s) my health information by email, fax, in person, phone, and or by text. All verbal, written, or electronically obtained communication is to be considered a part of my medical record. A copy of the Notice of Privacy Practices is available to me. I have either already read it, am currently aware of my privacy rights, or have a previous copy from another office. I recognize that a new copy is available to me at any time should I ask for it.

If I have future questions I am obligated to ask for clarification. I understand the above consent items and by signing below, agree to current and future evaluation and or treatment.

Patient:______________________ **Adult signature:**______________________________ **Date:**___________

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- **Financial Policies**

- **Deductibles, Co-pays, etc., are due at time of service**. To clarify, it is inefficient and cost prohibitive to spend $2 to mail a $50 bill. Please help us run an efficient and stress free office by taking care of your financial obligations at the time of your visit. You have the option to keep a payment card on file for expedited service. If you are experiencing a financial hardship, it is your responsibility to address this with a staff prior to your visit so we can make appropriate arrangements.

- We respect your time by reserving a unique appointment for you. We ask that you respect ours. **If you cancel within 24 hours or miss an appointment there will be a $50 fee**. If you are using our Online scheduling you can easily reschedule your own appointment up to 24 hours prior to your appointment. If you need to change an appointment less then 24 hours before you are scheduled to be seen we ask that you make a phone call our office so we can immediately try to fill that spot. If we can fill it we can spare you the fee. Please leave a voice message if we are unavailable. We **do not accept email changes to cancel appointments.**

- If you bounce a check we won't be upset but you will be charged **$25** that our bank will charge us.

- If you are involved in a **car accident, or work injury** it is your responsibility to inform us prior to treatment. We cannot change a bill that is already sent to your Insurer. If you don't tell us prior to, and it is submitted to insurance, your insurer could potentially deny payment, and you might be responsible for cost of services.

- If you are or become a **Medicare** person please be aware that Medicare pays for spinal manipulation for acute care problems. Examinations, re-exams, changes in diagnosis, traction, massage, exercise instruction or anything other than manipulation of the spine will not be paid by Medicare or a secondary insurance. Medicare will not pay for care that is considered 'Wellness or Supportive.' Your doctor will always inform ahead of time if your care is considered non acute. Patients are then responsible for uncovered services. By signing below you are authorizing us to bill your provider. We will estimate the uncovered portion of your visit and ask that you please pay at the time of service so we don't have to spend $2 to collect $20. If this is at all unclear please ask us to help clarify.

- The cost of using HSA cards, debit and or credit cards have become much too high and common. As health care providers we cannot price adjust our costs to offset these fees (co-pays, service rates & deductibles are fixed by the Insurer). In order to best serve you, we strive to allow the use credit cards but we ask that our patients offset 2.5% of the transaction cost. If you refuse this offset simply ask to speak with a staff person or doctor privately to make special arrangements.

- It is my responsibility to make this office aware of any insurance changes. I authorize release of information to and from my Insurance Companies. I authorize the doctors and staff to act as my agents in helping me obtain payment from my Insurance Companies and authorize payment direct to the doctor. It is my responsibility to inform the office immediately if there has been any change in complaint or if I sustained a new injury from home, work, or auto accident. If payment is not made by my insurer in a reasonable time period I will pay for services and request reimbursement directly from my appropriate 3rd party. I understand that verification of insurance benefits is not a guarantee of payment. I understand that I am responsible for any portion of charges not covered by my insurance or monies paid directly to me by my insurance company, attorney or settlement due to this office and that I will make such payment within 30 days of receipt. If I do not provide this office with all necessary/current billing information in a timely manner, then I may be responsible for the unpaid portion of my bill.

- **By signing below, I understand and accept the above listed policies.**

- **Patient:____________________ Adult signature:_________________________ Date: _____________**