CHANTILLY CHIROPRACTIC CENTER
PAGE CHIROPRACTIC REHABILITATION & WELLNESS

Patient Registration

PATIENT INFORMATION

Patient Name: _____
Last, First, Middle
Full Address: _____
Street, City, State, Zip
Phone: (Home) _____ (Work) _____ (Cell) _____

☐ I authorize Chantilly Chiropractic Center or Page Chiropractic Rehabilitation & Wellness to leave a message on all answering services.

Gender: M or F Birth Date:____/____/____ Marital Status: S___M___D___W___ Email:_____
Social Security # _____-_____-_____ Driver's License #: _____
Employer's Name _____ Occupation _____
Employer's Full Address _____
Street, City, State, Zip

Emergency Contact _____
Name, Relationship, Phone Number
Primary Care Physician _____ Referred By _____
Spouse's Information
Spouses Name: _____ Birth Date___/___/____ SS#_____
Employer _____ Occupation: _____ Phone #_____

☐ I authorize Chantilly Chiropractic Center or Page Chiropractic Rehabilitation & Wellness to leave or give information to a spouse, emergency contact, or any member of my household.

HEALTH INSURANCE INFORMATION

Primary Health Insurance Name: _____ Phone _____
Insured's Name: _____Relationship _____ Insured's DOB ____/_____/_____
Member ID#: _____ Group #_____ Effective Date of Coverage ____/____/_____

The information provided above is true to the best of my knowledge. I understand that I may be billed administrative and filing fees for withholding information as it relates to my medical history and insurance coverage.
Print Name:_____ Signature:_____ Date:_____

PLEASE CIRCLE ONE

#1 I will pay at time of service immediately after any procedures, including co pays, coinsurances, and deductibles as required by my insurance company.

#2 I prefer to be billed on my credit card for any charges relating to my care and treatment and with the signature below I authorize Chantilly Chiropractic Center or Page Chiropractic Rehabilitation & Wellness to charge any of these charges on the credit card listed below:
VISA / MasterCard Account #: _____
CVV Code_____ **Expiration Date:** _____

Print Name:_____ Signature:_____ Date:_____

FINANCIAL POLICY, INFORMED CONSENT AND WAIVER
INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to Chantilly Chiropractic Center or Page Chiropractic Rehabilitation & Wellness all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature:_____ Date:_____

INSURANCE AUTHORIZATION OF TREATMENT

1. I am ultimately responsible for full payment for any and all services rendered.
2. I am considered a CASH patient until I have provided completed insurance forms, and that your office has qualified and accepted my coverage, otherwise I pay at the time of service.
3. I must pay deductibles, co pays and coinsurance at the time of service.
4. Insurance Benefits quoted by my insurance company are NOT a guarantee of benefits or payment.
5. Chantilly Chiropractic Center and Page Chiropractic Rehabilitation & Wellness make every attempt to receive authorization of treatment from insurance companies for treatment received at one of our facilities. However, there may be times when the insurance company does not provide this authorization in a timely or correct manner. Chantilly Chiropractic Center and Page Chiropractic Rehabilitation & Wellness will submit claims as a courtesy to me. If my insurance carrier has not paid a claim within the terms of the contract within 60 days of submission, Chantilly Chiropractic Center or Page Chiropractic Rehabilitation & Wellness will submit an appeal one (1) time. If the claim is not paid within 30 days of the appeal I will be responsible for taking an active part in the recovery of my claim. After 90 days, I will be responsible for the balance and I authorize the use my credit card, (if supplied) to collect full payment, otherwise I must remit payment in full upon receipt of the bill.
6. In the event I discontinue my plan of care prior to the doctor's consent, I am responsible for any outstanding balance and the courtesy of insurance assignment is immediately discontinued.
7. If my account is turned over to collections, I agree to pay all court costs and 33% of attorney fees.
8. I understand that I can be charged a $50.00 NO SHOW fee for any appointment not canceled in advance.
9. I understand that I will be charged a one-time new patient fee of $20.00 to cover any disposable products which are not covered by my insurance.

TREATMENT CONSENT AND WAIVER

I hereby request and consent to the performance of chiropractic and/or physical therapy procedures, including various modes of physical therapy and diagnostic x-rays, on me (or for the patient I am legally responsible for) by the doctor of chiropractic employed by Chantilly Chiropractic Center and Page Chiropractic Rehabilitation & Wellness.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic/physical therapy there are some risks to treatment, including but not limited to, fractures, disc injuries, stroke, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all the risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, in my best interest.

NOTICE OF PRIVACY PRACTICES AND PATIENT'S RIGHTS AND RESPONSIBILITIES

Please Check:

☐ I acknowledge that I read and/or was offered a copy of the Notice of Privacy Practices & Patient's Rights and Responsibilities by Chantilly Chiropractic Center and Page Chiropractic Rehabilitation & Wellness.

Print Name:_____ Signature:_____ Date:_____

Witness _____ Date_____

CONSULTATION INFORMATION

PRESENT COMPLAINT

Symptoms & Rating (After each symptom, rate your pain on a scale from zero (least severe) to 10 (most severe)

Please Be specific:_____

List Symptoms, Pain Level After Each Symptom

When did the symptoms first appear? _____

What makes the symptoms worse or increase? _____

What makes the symptoms better or decrease? _____

Please identify activities that you are unable to perform due to this condition:

_____

Have you seen another health care provider for this problem? YES or NO If yes, who? _____

Please check (✓) to indicate if you have had any of the following symptoms:

☐ constant	☐ mild	☐ sharp	☐ dull	☐ achy
☐ frequent	☐ moderate	☐ burning	☐ stiffness	☐ swelling
☐ occasional	☐ severe	☐ numbness	☐ tingling	☐ other

REVIEW OF SYSTEMS

Do You Currently Experience:

• Any generalized symptoms such as weakness, fatigue, fever, chills, night sweats, fainting, change in sleep pattern, unexplained weight loss, unexplained weight gain or others? YES NO If yes, please explain _____

• Any skin problems such as rashes, itching, dryness, sores, changes in skin color, changes in moles, changes in hair, changes in fingernails, or others? YES NO If yes, please explain _____

• Any lung problems such as coughing, phlegm, shortness of breath, difficulty breathing, wheezing, congestion, coughing blood, or others?
YES NO If yes, please explain _____

• Any heart problems such as a murmur, palpitations, rapid heartbeat, extremity swelling, chest pain, cold extremities, high/low blood pressure, or others? YES NO If yes, please explain _____

• Any gastrointestinal problems such as stomach pain, nausea/vomiting, diarrhea, gas/bloating, constipation, rectal bleeding, change in appetite/thirst, change in stools or others? YES NO If yes, please explain _____

• Any genitourinary problems such as painful urination, blood in urine, frequent urination, incontinence, urgency, change in urine appearance or others? YES NO If yes, please explain _____

• Any musculoskeletal problems such as muscle pain, muscle weakness, muscle twitching, joint stiffness, joint pain, joint swelling, hot joints or others? YES NO If yes, please explain _____

• Any neurological problems such as numbness, tingling, weakness, paralysis, loss of memory, loss of sensation, difficulty with coordination, dizziness, difficulty with speech or others? YES NO If yes, please explain _____

• Any psychiatric problems such as depression, anxiousness, hallucination, drug addiction, suicidal thoughts, difficulty sleeping or others?
YES NO If yes, please explain _____

• Any eye, nose or throat problems such as blurred vision, double vision, eye pain, hearing loss, ringing in ear, vertigo, sinus problems, loss of smell, hoarseness, difficulty swallowing or others? YES NO If yes, please explain

_____

PAST MEDICAL HISTORY

Please check (✓) to indicate if you have had any of the following:

☐ AIDS/HIV	☐ Cancer	☐ Gout	☐ Multiple Sclerosis	☐ Stroke
☐ Alcoholism	☐ Cataracts	☐ Heart Disease	☐ Mumps	☐ Suicide Attempt
☐ Anemia	☐ Chicken Pox	☐ Hepatitis	☐ Osteoporosis	☐ Thyroid Problems
☐ Anorexia	☐ Diabetes	☐ Hernia	☐ Pacemaker	☐ Tonsillitis
☐ Appendicitis	☐ Drug Abuse	☐ Herpes	☐ Pneumonia	☐ Tuberculosis
☐ Arthritis	☐ Emphysema	☐ High Cholesterol	☐ Polio	☐ Tumors
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Prostrate Problems	☐ Typhoid Fever
☐ Ulcers	☐ Fractures	☐ Blood Disorders	☐ Liver Disease	☐ Psychiatric Care
☐ Breast Lump	☐ Glaucoma	☐ Measles	☐ Rheumatoid Arthritis	☐ Vaginal Infections
☐ Bronchitis	☐ Goiter	☐ Migraines	☐ Rheumatic Fever	☐ Venereal Disease
☐ Bulimia	☐ Gonorrhea	☐ Mononucleosis	☐ Scarlet Fever	☐ Whooping Cough

Please list any major illness, injuries, auto accidents, or surgeries

ILLNESS, INJURY, OR SURGERY	DATE	TREATMENT