PATIENT INFORMATION

PERSONAL INFORMATION

Today's Date: _____

Check the type of care desired: ❑ Temporary Relief ❑ Lasting Correction

Name: _____ **Social Security Number:** _____ -_____-_____

Date of Birth: _____ -_____-_____ **Age:** _____ **Height:** _____ **Weight:** _____

Check Marital Status: ❑ Married ❑ Single ❑ Other **Sex:** ❑ Male ❑ Female

Address: _____ **City:** _____

State: _____ **Zip Code:** _____

Home Phone: ( )_____ **Work Phone:** ( )_____ **Cell:** ( )_____

Email Address: _____

Nearest Relative: _____ **Phone:** ( )_____

Address: _____ **City:** _____

State: _____ **Zip Code:** _____

Are you pregnant? ❑ No ❑ Yes Date of Last Menstrual Cycle: _____

EMPLOYMENT INFORMATION

Occupation: _____ **Employer:** _____

Employer Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **Phone:** ( )_____

Spouse's Name: _____ **Employer:** _____

Employer Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **Phone:** ( )_____

PAYMENT INFORMATION

How will payment be made? *(please check one of the following)*

❑ Cash ❑ Check ❑ Credit Card ❑ Auto Insurance ❑ Health Insurance ❑ Worker Comp

Insurance Company _____ **Policy #** _____ **Group #** _____

Name Of Primary: _____ **Social Security Number:** _____ -_____-_____

Fees are payable at the time X-rays, examinations/treatments are received unless other arrangements are made in advance. X-rays remain the property of the clinic. All accounts over (30) days delinquent will be subject to a 1.5% monthly periodic interest charge to the unpaid balance. All accounts over (60) days delinquent will be turned over for collection or judgment in small claims court. All collection fees, filing fees, attorney fees and court costs incurred by this office in collecting accounts will be charged to the patient.

**By signing below I acknowledge that I have read and understand the HIPPA regulations regarding the privacy of my records and that I reserve the right to designate release of information to any third party.*

Patient Signature: _____

Guardian/Parent Signature Authorizing Care: _____

PATIENT HISTORY FORM

Patient Name: _____ **Date:**_____

What is your primary reason for seeking care today? _____

Have you missed any work due to this condition? ❑ No ❑ Yes

What dates? _____

What treatment have you received for this condition?

❑ Physical Therapy ❑ Surgery ❑ Medication ❑ None

❑ Chiropractic Services ❑ Other _____

Name and address of previous doctor(s) who have treated your condition: _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____ Urine Test _____

What expensive diagnostic test have you had?

❑ MRI ❑ CT ❑ EMG

❑ Other _____

List all prescription and non-prescription drugs you are currently using: _____

_____

List any surgeries you have had: _____

_____

Please list any past broken or fractured bones: _____

Have you ever suffered from:

❑ Dizziness	❑ Tuberculosis	❑ Digestive Disorders	❑ Asthma	❑ Arthritis
❑ High Blood Pressure	❑ Sinus Trouble	❑ Headache	❑ Nervousness	❑ Diabetes
❑ Numbness	❑ Anemia	❑ Migraine Headaches	❑ Heart Disease	❑ Stroke
❑ Arteriolosclerosis	❑ Osteoporosis	❑ Bleeding Disorders	❑ Cancer	

Other _____

_____

Do you exercise? ❑ No ❑ Yes

What type(s) and frequency of exercise? _____

_____

_____

What activities does your job entail?

❑ Prolonged Sitting	❑ Lifting	❑ Computer Use	❑ Twisting
❑ Prolonged Standing	❑ Stooping	❑ Repetitive Motions	

How would you rate your diet? (1 being poor and 10 excellent) **1——————5——————10** **Daily H2O intake _____oz.**

Do you take vitamins? ❑ No ❑ Yes

What type(s)? _____

Would you say your sleep is: ❑ Good ❑ Fair ❑ Bad

Your sleeping position is: ❑ Back ❑ Side ❑ Stomach

Do you smoke? ❑ No ❑ Yes How much? _____

How would you rate your stress levels? **Home: 1——————5——————10**

Work: 1——————5——————10

Overall how do you feel today? (1 being terrible and 10 being healthy) **1——————5——————10**

Patient Name: _____

COMPLAINT(S): List in order of severity

1) _____

Date when symptons first appeared: _____

❑ Constant 100% ❑ Frequent 75%

❑ Intermittent 50% ❑ Occasional 25% ❑ Rare 10%

Describe any related accidents or falls _____

_____

_____

What makes symptoms increase? _____

What gives relief? _____

Type of Pain:

❑ Sharp ❑ Dull ❑ Aching ❑ Burning

❑ Throbbing ❑ Numb ❑ Other _____

Does the pain radiate? ❑ No ❑ Yes

Where to? _____

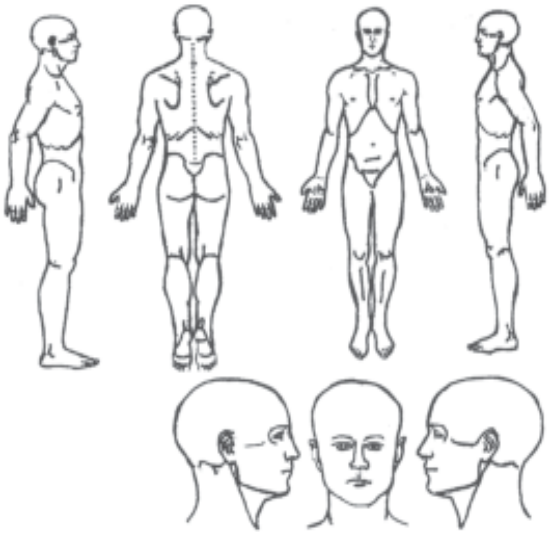
How bad is the pain? (0 no pain - 10 unbearable)

0————5————10

Doctors seen: _____

Does this interfere with: ❑ Work ❑ Sleep ❑ Activities

****Please mark areas of pain on figures below**



What medication(s) have you taken for this condition?

_____

_____

_____

_____

---

2) _____

Date when symptons first appeared: _____

❑ Constant 100% ❑ Frequent 75%

❑ Intermittent 50% ❑ Occasional 25% ❑ Rare 10%

Describe any related accidents or falls _____

_____

_____

What makes symptoms increase? _____

What gives relief? _____

Type of Pain:

❑ Sharp ❑ Dull ❑ Aching ❑ Burning

❑ Throbbing ❑ Numb ❑ Other _____

Does the pain radiate? ❑ No ❑ Yes

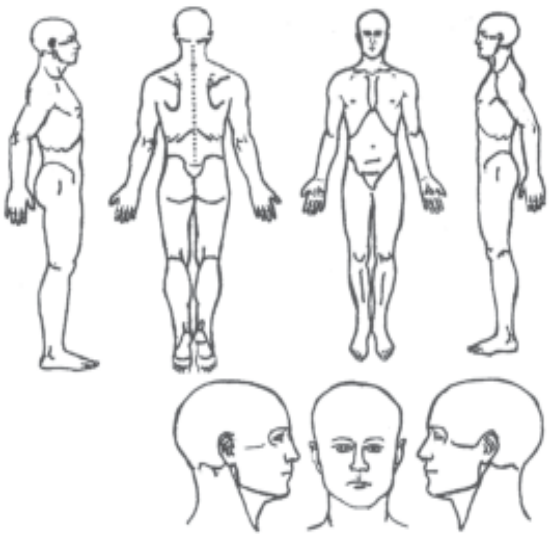
Where to? _____

How bad is the pain? (0 no pain - 10 unbearable)

0————5————10

Doctors seen: _____

Does this interfere with: ❑ Work ❑ Sleep ❑ Activities



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Patient Name: _____

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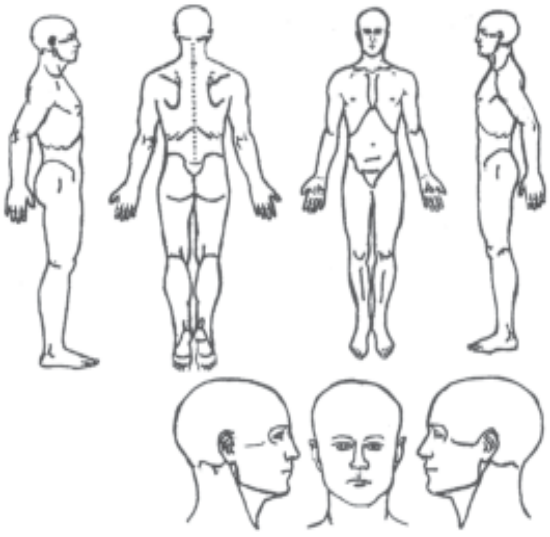

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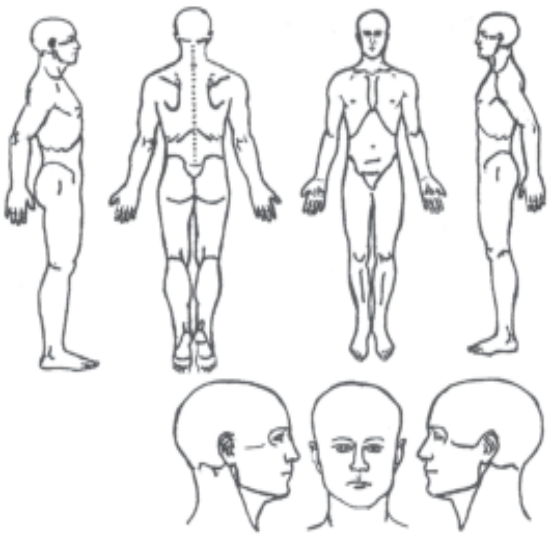

What medication(s) have you taken for this condition?

_____

_____

_____

_____

Date: _____

PATIENT NAME: _____

Please review the below listed diseases and conditions and indicate those that are current health problems of a family member by the designation **'C'** under his or her column. The designation **'P'** should be used ot indicate a past problem. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form.

CONDITION	FATHER Age ____	MOTHER Age ____	SPOUSE Age ____	BROTHER(S) Age ____	Age ____	SISTER(S) Age ____	Age ____	CHILDREN Age ____	Age ____	Age ____
Arthritis										
Asthma										
Back Trouble										
Bursitis										
Cancer										
Carpal Tunnel										
Constipation										
Diabetes										
Disc Problems										
Emphysema										
Epilepsy										
Fibromyalgia										
Headaches										
Heart Trouble										
High BP										
Insomnia										
Kidney Trouble										
Liver Trouble										
Migraine										
Nervousness										
Neuritis										
Pinched Nerves										
Scoliosis										
Sinus Trouble										
Stomach Trouble										
Other:										
Other:										

AUTHORIZATION OF RELEASE OF RECORDS

I hereby authorize _____ to release my complete medical records and X-ray reports to _____ .

For the injury or accident of _____ to:

Progressive Chiropractic PLLC
4664 South Blvd. Ste 101
Virginia Beach, VA 23452
(757) 490-8555
(757) 490-3838 Fax

This information is for the one recipient above only. Under the Family Education and Privacy Act 1974 and in compliance with all HIPA laws and regulations. This information cannot be given to any other individual without the patients prior consent.

This authorization will expire one year from the date below.

Date: _____ Patients Signature: _____

Patients Printed Name _____

Social Security #: _____

Birth Date: _____

Witness: _____

Date Requested: _____

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our **Financial Policy** which we require that you read and sign prior to any treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS AND VISA/MASTERCARD. WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

INSURANCE for patients who have insurance we will, at no additional charge, file their claims for payment. If your coverage cannot be verified, services rendered on your initial visit must be paid in full. Partial payment (50%) of the initial visit is allowed if your insurance can be verified but satisfaction of your annual deductible cannot be verified. If we can verify satisfaction of your annual deductible, either from your insurance company or from your **Explanation of Benefits** provided by you, we will collect only your co-payment. Payment of the co-payment may be made either at the time of service, or on a weekly basis, depending on your treatment schedule.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 60 days, the balance of your account will be automatically transferred to your credit card or you must be approved on our **Extended Payment Plan.**

Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates. Please be aware some services provided may be "non-covered" services and not considered reasonable and necessary under the **Medicare Program** and/or other medical insurance.

On all **DELINQUENT ACCOUNTS** over **30 days old,** there will be a finance charge of **1-1/2% per month** computed and added to the unpaid balance. All unpaid and unresolved balances for which no payments have been received for **60 days** will be automatically turned over for collection. All collection fees will be added to your account and will be your responsibility, should such action prove unavoidable. **DELINQUENT ACCOUNTS** over **60 days** will be charged a **35% fee** and accounts over **90 days** will be charge a **50% fee.**

ALL RETURNED CHECKS WILL BE CHARGED A $15.00 SERVICE CHARGE.

Thank you for understanding our **Financial Policy.** Please let us know if you have any questions or concerns.

I have read this Financial Policy (above). I understand and agree to this Financial Policy:

Signature Patient or Responsible Party: _____

Date: _____

MISSED APPOINTMENT POLICY

Please be aware that as of May 28, 2008 there will be a $40.00 charge for all missed appointments when a call is not received at least one hour prior to the appointment.

Of course, the doctor would much rather see your spine than your money, so please keep your appointment and follow up your treatment plan!

Patients Signature: _____

Date: _____

PROGRESSIVE CHIROPRACTIC
DIRECT PAYMENT AUTHORIZATION FORM

Patient Name: _____ **Date:** _____

Employer: _____

Claim Group: _____

Social Security/ID Number: _____

I hereby instruct and direct _____ Insurance Company to pay by check made payable to:

PROGRESSIVE CHIROPRACTIC PLLC
4664 South Blvd. Ste 101
VIRGINIA BEACH, VA 23452

for professional services performed for my injuries. If current policy prohibits direct payment to the doctor, I hereby also direct you to make out the check to:

_____ and _____, D.C.

and mail to:

PROGRESSIVE CHIROPRACTIC PLLC
4664 South Blvd. Ste 101
VIRGINIA BEACH, VA 23452

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature: _____

Witness: _____

Signature of Claimant: _____
(if other than the policyholder)