# PATIENT INFORMATION

PERSONAL INFORMATION

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

Today’s Date:

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:

Emergency Contact: Relationship:

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 (if different from above): 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 HIPAA 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 DC Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Date of Last: Physical Exam

Spinal X-Ray

Blood Test

Last Adjustment:

What expensive diagnostic test have you had?

* MRI  CT  EMG  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all prescription, non-prescription (OTC) drugs and vitamins you are currently using:

List any surgeries you have had:

List ALL serious LIFETIME injuries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any past broken or fractured bones: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you ever suffered from:

Other:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  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 |  |

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? (0 being poor and 10 excellent) 0——————5——————10 Daily H2O intake: oz.

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: 0——————5——————10 Work: 0——————5——————10

Overall how do you feel today? (0 being terrible and 10 being healthy) 0——————5——————10

# Patient Name: Date:

COMPLAINT(S): List in order of severity

1) Date when symptoms 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:

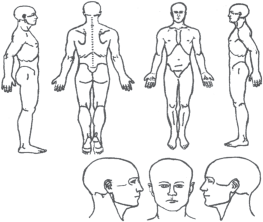
* + Sharp  Dull  Aching  Burning
  + Throbbing  Numb  Other

Does the pain radiate?  No  Yes

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

0——————5——————10

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

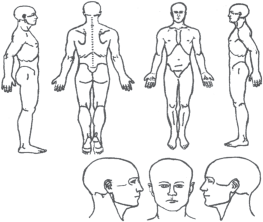


What medication(s) have you taken for this condition?

Doctors seen: Does this interfere with:  Work  Sleep  Activities

2) Date when symptoms 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)

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

0——————5——————10

Doctors seen: Does this interfere with:  Work  Sleep  Activities

# Patient Name: Date:

COMPLAINT(S): List in order of severity

3) Date when symptoms 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:

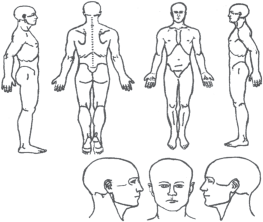
* + Sharp  Dull  Aching  Burning
  + Throbbing  Numb  Other

Does the pain radiate?  No  Yes

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

0——————5——————10

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

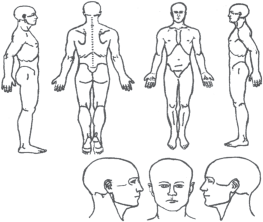


What medication(s) have you taken for this condition?

Doctors seen: Does this interfere with:  Work  Sleep  Activities

4) Date when symptoms 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)

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

0——————5——————10

Doctors seen: Does this interfere with:  Work  Sleep  Activities

PATIENT NAME: Date:

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 to 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 HIPAA 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: Patient's Signature:

Patient's 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:

**Late, Missed or No-Show Appointment Policy**

Starting **April 1, 2019**, there will be a **$35.00 fee** charged for **ALL** late and/or missed appointments.

**LATE APPOINTMENTS:**

You are considered late if you arrive **15 minutes or later** to your appointment. If you arrive late, your appointment may need to be rescheduled or you may have to wait longer to be seen.

**MISSED APPOINTMENTS:**

Any appointment cancelled or rescheduled **within 24 hours** of original appointment time, regardless if the office is open or closed, is considered a missed appointment. If the office is closed and you need to cancel and/or reschedule, you can either call and leave a voicemail message or email us at [www.progressivevb@gmail.com](http://www.progressivevb@gmail.com).

Please be courteous and notify us if you cannot make your appointment so we can get you rescheduled as soon as possible.

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PROGRESSIVE CHIROPRACTIC

DIRECT PAYMENT AUTHORIZATION FORM

Patient Name: Date:

Employer:

Claim Group:

Social Security/ID Number:

I hereby instruct and direct check made payable to:

to pay:Insurance Company

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:

PROGRESSIVE CHIROPRACTIC PLLC

4664 South Blvd. Ste. 101 VIRGINIA BEACH, VA 23452

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)*