# 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:

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 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:

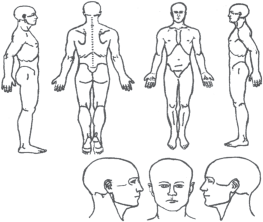
* + Sharp  Dull  Aching  Burning
  + Throbbing  Numb  Other

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

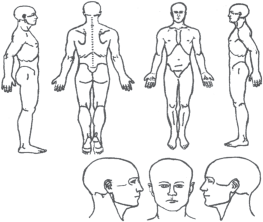


What medication(s) have you taken for this condition?

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:

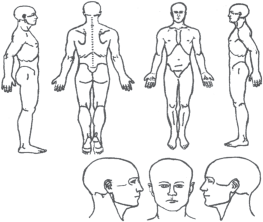
* + Sharp  Dull  Aching  Burning
  + Throbbing  Numb  Other

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

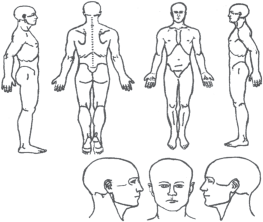


What medication(s) have you taken for this condition?

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient Name: Date:

Date of Accident: Time of Accident:

Please explain in detail how your accident happened:

What is the estimated cost/damage to the vehicle you were in?

Were you the?

* + Driver  Passenger  Front  Back  Right  Left

Were you wearing a seatbelt?  No  Yes

If yes, was it a:  Lap Seatbelt  Shoulder Strap Seatbelt Please draw out your accident

Were you struck from?

* + Behind  Front  Left Side  Right Side

Was your head looking?

* + Front  Right  Left

Were your arms on the?

* + Steering Wheel  Dashboard

Were your legs on the?

* + Floor  Clutch  Brake

Was the trunk of your body pointed?

* + Straight Forward  Turned Right  Turned Left

Were you braced for the accident?  No  Yes Were you thrown about:  Forcefully  Violently On what part of the automobile did your follow body parts hit?

Head

Right/Left Shoulder Right/Left Hip Right/Left Knee

Chest

Right/Left Arm Right/Left Leg Other

Please explain:

Did you receive any injury or bruise from the seatbelt?  No  Yes

If YES, then describe:

Were you knocked unconscious?  No  Yes How Long? Where did you feel pain after the accident?

Did you go to a hospital or Dr?  No Yes Name of Dr. or Hospital: What parts of your body were X-rayed at the hospital?

How long did you stay at the hospital?

# AUTOMOBILE INSURANCE FORM

Patient Name: Date of Accident:

Was this your vehicle?  No  Yes State the Accident Happened:

If not, who is the owner?

Address: City:

State:

Zip Code:

Phone: ( )

Year/Make of Vehicle: License Tag No:

Name of *Your* Insurance Company:

Address: City:

State:

Zip Code:

Phone: ( )

Claim Number: Policy Number:

Your Agent’s Name:

Does your auto policy include medical coverage?  No  Yes Has this been reported?  No  Yes

Name of Driver in *other* vehicle:

Phone: ( )

*Other* Driver’s Insurance Company:

Address: City:

State:

Zip Code:

Phone: ( )

Claim Number: Policy Number:

Their Agent’s Name:

Have you retained an attorney?  No  Yes

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: City:

State: Zip Code:

Do you have health insurance?  No  Yes

Name of Insured:

Name of Patient:

Insurance Company

Policy Number: Group Number:

Address: City:

State: Zip Code:

# PROGRESSIVE CHIROPRACTIC PLLC

4664 South Blvd. Ste 101 VIRGINIA BEACH, VA 23452 (757) 490-8555

ASSIGMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION

(“Agreement”)

I hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities (“payers”), which may elect or be obligated to pay benefits to me or any medical conditions, accidents, injuries, or illness, past or future (“conditions”), to pay directly to and exclusively in the name of David Ranzette, D.C. or “office” such sums as may be owing to the office for charges incurred by me, including but not limited to, charges for treatment, narrative reports, depositions, testimony and any other charges; however, nothing in this Agreement shall be constructed as an election of remedies under any statutory lien law. Furthermore, in the event of conflict between the assignment and the grant of contractual lien the assignment shall control. For the purposes of this as any proceeds relating to commercial health or group insurance, disability benefits, worker’s compensation benefits, medical payments benefit, personal injury protection, lost wages benefit, lost service benefits, no-fault coverage, uninsured and underinsured motorist coverage third-party liability distributions, attorney retainer agreements , and other benefit proceeds payable to me for the purposes stated herein, regardless whether such proceeds are related to my charges or not.

I further agree that, in the event a payer refuses to pay David Ranzette, D.C., pursuant to this Agreement, I hereby assign, in so far as permitted by law, all of my rights, remedies and benefits to David Ranzette, D.C., to the extent of my charges, as well as any and all causes of action that I might have assigned such payer, to prosecute such causes of action either in my name or in the office name, and to settle or otherwise resolve such causes of action as the office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office. I further direct each attorney to provide immediate notice of the office regarding any funds received by the attorney relating to my accident, to promptly pay such office, and to provide a full accounting of such funds to the office upon request.

I hereby direct all payers to release to the office any information regarding any coverage of benefits which may have included, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims.

I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this agreement. I hereby direct this office to file a copy of this agreement, together with the applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize David Ranzette D.C. to endorse/sign my name on any and all checks listing me as a payee which are presented to this office for payment on account relating to me, my spouse or any of my dependents. I further authorize the office to apply any credit balance on charges incurred by me or any other outstanding charges still owed by me, my spouse or my dependents, regardless of whether these others charges are related to my condition.

I understand that I have the option to consult my insurance agent or attorney before signing this form and that I am not required to execute this form to receive care. I understand that I remain personally responsible for the total amount due to David Ranzette D.C. for their services. This agreement does not constitute any consideration of this office to await payments and it may demand payments from me immediately upon rendering services. I will be responsible for payment and will reimburse David Ranzette D.C. for all costs of such collection efforts, including but not limited to, all court costs and 33.33% attorney fees.

This agreement shall not be modified or revoked without written consent of David Ranzette, D.C. and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this agreement.

I agree that each and every provision of this agreement is reasonably necessary for the protection of the rights and interest of David Ranzette D.C. and I. However, should any provision of this agreement is found to be invalid, illegal or unenforceable or for any reason cease to be binding on any party hereto, all other portions and provisions of this agreement shall nevertheless, remain in full force and effect**. (\_\_\_\_\_\_)** Initial here that you have read or had the opportunity to read the proceeding agreement.

Furthermore I acknowledge that I may consult with my insurance agent or attorney before signing this form; and that I am not required to execute this form in order to receive care.

**NOTICE:** Automobile accident patient

If you have been in an automobile accident, you may be entitled to payment from your automobile insurance if you have medical expense benefits coverage. By signing this agreement of benefits form you are giving to your health care provider the right to receive some or all of that payment directly from your automobile insurance company.

If you have health insurance and your healthcare provider is in-network: as long as you provide information necessary to verify your health insurance coverage, the healthcare provider may only bill the amount you owe for any copayment, coinsurance, deductibles or non-covered services to your automobile insurance and you may be entitled to any remainder of your automobile insurance benefits.

If you do not provide information necessary to verify your health insurance coverage, do not have health insurance, or your healthcare provider is not in your health insurer’s provider network: your healthcare provider may bill their full charges to you automobile insurance.

**You may want to consult your insurance agent or attorney before signing or initialing this form. You are not required to sign/initial this form to receive care. (\_\_\_\_\_\_\_)** Initial here that you have read or had the opportunity to read the proceeding Notice Provision. I agree, signing as guarantor, to all these agreements, that I have read and had the opportunity to read the Notice Provision set forth above and waive or default in payment and prejudgment against patient.

Patient Name (please print)

Patient Signature (parent or guardian)

Date:

The undersigned, being the attorney of record for the above patient, does hereby agree to observe all terms of the above and agrees to withhold such sums for services rendered at Progressive Chiropractic, from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor of the clinic above. I make these agreements with the knowledge that these are the stated wishes of my client and I fully honor those wishes.

Attorney 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)*

Personal Injury Deferred Payment Policy.

When seeking care in our office for injuries where a third party is responsible for payment, and there are no other payment options (i.e. medpay, private insurance), we

offer a deferred payment option. This option is offered on a case by case basis. If Med. Pay is received by any other party and not promptly forwarded to our office the deferred payment option will be canceled.

In cases where an attorney has been retained, the deferment is continued provided the attorney pursues the case actively and allows our office to verify status each month. If at any time our office feels the attorney is not addressing the case in a timely manner or the attorney refuses to verify the status we may decide, after consultation with the patient, to cancel the deferred status.

In cases where the patient is seeking to settle the case by him/herself, we allow deferment for 45 days from the date the records are sent to the patient or third party. If at the end of those 45 days the case has not been settled OR attorney representation retained, payment will be due in accordance with the standard financial policy.

I have read the above deferment policy and agree with all the terms and conditions.

Sign X

Print

Date