NEW PATIENT APPLICATION

Welcome to our Holistic Center!
Please thoroughly complete all questions. Thank you.

Personal Information

Name:_____ Today's Date:_____

Address:_____

City/State:_____ Zip:_____

E-mail:_____

Phone: Home:_____ Work:_____ Cell:_____

Fax:_____ Marital status: M/W/D/S Birth date:____/____/____

Age:_____ Social Security #:_____

Spouse's name:_____

Children's names & ages:_____

Hobbies or interests:_____

Who may we thank for referring you? _____

Have you ever been to a Chiropractor?_____

If so, when was the last time you were there?_____

Chiropractic techniques you've had success with:_____

General Practitioner:_____Phone:_____

Other Specialists you are currently under care with:

Name:_____Phone:_____

Name:_____Phone:_____

Name:_____Phone:_____

Insurance Information

Insurance Company Name:_____

Policy #:_____ Group#_____

Policy Holder Name:_____DOB_____

Relationship to Patient:_____

WE LOOK FORWARD TO CHANGING YOUR LIFE!!!!

Employer Information

Name:_____ Phone:_____

Address:_____

Occupation:_____

Health reasons for consulting our office:

1._____ 2._____

3._____ 4._____

Have you had similar problem(s) before?_____ How long?_____

Explain:_____

Immediate family with similar problems?_____

Is this a result of an auto or work injury? _____ If so, when?_____

If this is a work injury, is there a panel chiropractor that your company's Worker's Compensation Insurance requires you to see in the first 90 days? If so, please list their name.

_____

Other doctors who have treated this problem: _____

_____

Surgery you have had:_____

Medication(s) your currently take:_____

Is there a chance you are pregnant? _____

What have you heard about chiropractic care?_____

_____

Do you know what a subluxation is? If yes, please describe. _____

_____

What are your expectations for our office?_____

_____

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.

Patient or Guardian:_____ Date:__/__/__

Chiropractic

Wellness

Solutions

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal: to eliminate misalignments within the spinal column, which interfere with the expression of the body's innate wisdom. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

Adjustment: the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

Health: a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: a misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will commend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by other. Our ONLY practice objective is to eliminate major interference to the expression of body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

questions regarding the doctor's objectives pertaining to my care in this office have been answered to my plete satisfaction.

refore, accept chiropractic care of this basis.

t Initials_____ Date___/___/___

Office Policies for Chiropractic Wellness Solutions

Chiropractic Wellness Solutions is concerned for your health and well being.

A) WE NEED TO KNOW: We need to know immediately of any changes or problems in your health. In turn, this allows us to better serve you.

B) MISSED/CANCELED APPOINTMENTS: If for any reason, you are unable to keep an appointment, we require that you call us.

C) PAYMENT OPTIONS:

1. Initial visit fees are payable on the first visit.
2. Returned checks and balances over 30 days may be subjected to additional fees and interest charges of 2% per month.
3. All accounts not paid within 90 days will automatically be put through your personal credit card for collections or assigned to an outside collections agency at which time you will be responsible for any additional fees incurred from the collection agency.

D) INSURANCE: The privilege of insurance assignment begins when our office receives your insurance forms.

1. Deductible payments MUST be made prior to insurance submittal.
2. You are considered to be a cash patient until our office "qualifies" your coverage to determine the extent of benefits under your policy.
3. All co-payments are payable when services are rendered or at the end of each week.
4. Should you discontinue care for any reason other than discharge by the doctor, any and all balance due will become immediately payable in full, regardless of any claims submitted.
5. Our office does not promise that an insurance company will reimburse you for the usual and customary charges submitted by this office, nor will we enter into any dispute with an insurance company over the amount of reimbursement.
6. Since we do not own your policy, and, occasionally, we experience difficulty in collecting from the carrier, we may ask for your active assistance in rectifying this situation.
7. Ultimately, it is your responsibility to see that your account is paid.

8. If your Insurance Company submits a payment directly to you, it is your responsibility to forward this payment to our office. If this payment is not received within 10 days your credit card will be charged for the check amount.

Lastly, it is our goal to provide you with the finest quality chiropractic care available. If you have any questions with regard to your health care, or any of our policies, please let us know.

WELCOME TO OUR PRACTICE!!!

I, _____ have read and understand these rules and agree to abide by them.

_____ _____

Signature Date

Effective: 1/2006