

INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. (PLEASE PRINT.)

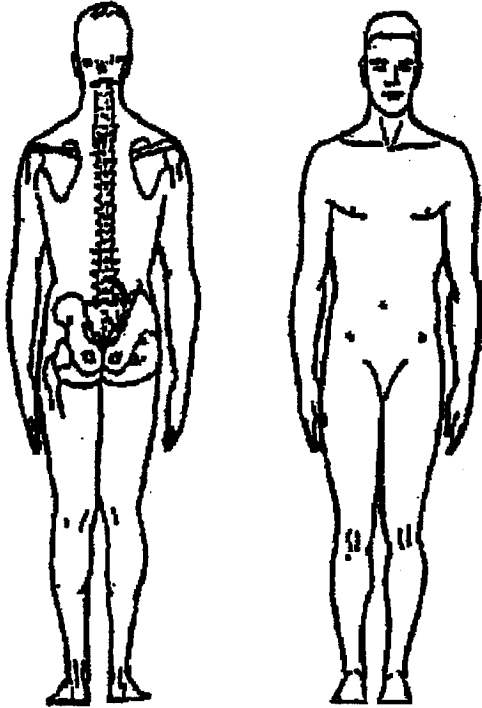
Today's Date _____

Name _____ Home Phone _____ Work Phone _____
 Cell Phone _____ E-Mail Address _____
 Address _____ City _____ State _____ Zip _____
 Age _____ Birth date _____ Marital Status: S M W D Number of Children _____

Please circle one payment type: Cash Check Master Card/Visa American Express

Your Employer _____ Occupation _____ Years On Job _____
 Employer Address _____ City _____ State _____ Zip _____
 Insurance Company _____ Your Social Security # _____
 Do you have Medicare? Yes ___ No ___ Do you have Medicaid? Yes ___ No ___
 Name of Spouse or Parent _____ Their Birthdate _____
 Spouse Employed By _____ Occupation _____ Years On Job _____
 Employer Address _____ City _____ State _____ Zip _____

Office Phone # _____ Spouse's SS# _____
 Driver's License # _____
 Does your spouse have health insurance at work? Yes ___ No ___



COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example; dull, sharp, consistent, off & on, when standing, when sitting, etc.....

MAJOR COMPLAINTS

(Please list any condition you are being treated for or are experiencing.)

Referred to our office by: _____

How payment will be made: _____ Type of Insurance: _____

_____ Cash _____ Worker's Comp. _____ Health Insurance
 _____ Check _____ Credit Card _____ Automobile Insurance Policy

Is your condition due to an accident? Yes ___ No ___ Date of accident? _____
 Type of accident? Auto ___ Work/On Job ___ At Home ___ Other _____
 Have you ever been in an auto accident? Past Year ___ Past 5 Years ___ Over 5 Years ___ Never ___

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I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered will be immediately due and payable. Overdue accounts maybe placed with an attorney or collection agency for collection. In the event an account is turned over to an attorney or collection agency, the patient or person responsible for patient's account agrees to pay an attorney's fee, court cost, finance charges and any other reasonable cost of collection.

Patient's Signature _____ Date _____
Or Guardian Signature _____ Date _____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

Insurance cases: On all insurance assignments, the deductible should be met in the beginning unless prior arrangements are made.

OFFICE FINANCIAL POLICY

CASH

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.
2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.

INSURANCE

1. If you have insurance, we will gladly accept assignment with the following exceptions and regulations, provided we have prior certification from your insurance company.
2. We accept assignment for the initial treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment per visit.
3. We accept assignment as a courtesy to you; you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.
4. Whenever you receive any worksheets from your insurance company or explanation of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine whether proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue you an overpayment check – it will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.
5. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.
6. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any

OFFICE FINANCIAL POLICY

denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.

7. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payment in full expected immediately; regardless of any claims submitted.
8. If you have questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the Doctor.

Thank you.

I have read and understand the Financial Office Policy and agree to abide by these terms.

Patient's Signature

Date

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 of 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 a 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 advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend 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 others. **OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference of the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.**

I, _____ have read and fully understand the
(print name)
above statements.

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

I, therefore, accept chiropractic care on this basis.

Signature

Date