First Name _____ MI _____ Date of Birth _____/_____/_____ Sex M/F

Last Name _____ Social Security Number _____

Address _____ City _____ State_____

Zip_____ Home Phone _____ Cell Phone_____

Work Phone _____ Email _____

Referred By _____

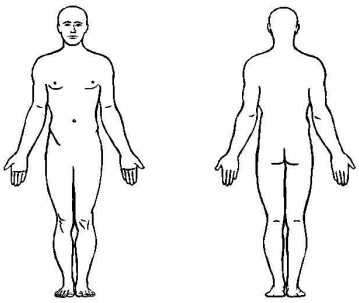
Emergency Contact

Name _____ Relationship _____

Home Phone _____ Work Phone _____

Describe your current problem and how it began:
□ Headache □ Neck Pain □ Mid-Back Pain □ Low Back Pain
□ Other _____
Is this? □ Work Related □ Auto Related □N/A
Approximate Date Problem Began _____
How Problem Began _____
Current complaint (how you feel today):
No Pain □1 □2 □3 □4 □5 □6 □7 □8 □9 □10 Unbearable Pain
How often are your symptoms present? □ 0-25% □26-50% □51-75% □76-100%
In the past week, how much has your pain interfered with your daily activities (i.e. work, social activities, or household chores?)
No Interference □1 □2 □3 □4 □5 □6 □7 □8 □9 □10 Unable to carry on
In general, how would you say your overall health right now is:
□ Excellent □ Very Good □ Good □ Fair □ Poor

Please mark and X on the picture where you have pain or other symptoms:



I certify to the best of my knowledge that all information heretofore provided is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this office, I understand that I am responsible for all services rendered. I agree to notify the doctor and/or billing manager immediately whenever I have any changes in my health condition or insurance plan coverage in the future. I understand that my doctor of chiropractic may need to contact my medical doctor if my condition needs to be co-managed; therefore I give authorization to contact his/her office.

Patient Signature: _____ Date: _____

MEDICAL RECORDS

Medical records release requires the patient to sign a Release of Records Form **before** records are released. In the interest of quality of care and quality control, we require these records be released directly to another physician of the patient's choice. Medical record will not be released to be hand carried by the patient, the patient's family member, or friends.

CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and associated modalities, including various modes of physiotherapy, on me (or the patient named below for whom I am legally responsible) by my doctor. I understand that, in any course of treatment, there are inherent risks. I understand the doctor is not able to anticipate and/or explain all the risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment through the course of treatment which he feels at the time, based on the facts then known, is in my best interests.

INSURANCE AUTHORIZATION & ASSIGNMENT

I authorize and request payments under my medical insurance programs be made directly to the above provider and/or this office for any services provided to me. I also authorize the provider to release any information necessary to facilitate payment of claims. I further permit copies and/or a digital copy of this authorization to be used in place of the original.

INSURANCE POLICY

If you (the patient/guardian) have insurance, we will gladly accept assignment provided that we have prior certification from your insurance company. Bear in mind, you are responsible for incurred charges should your insurance company fail to pay for any of those charges for any reason. We will not enter into any disputes between you and your insurance company. If additional information is required for payment from your carrier, you agree to comply and provide the information in a timely manner. If payment is made directly to you, the patient, you agree to deliver said payments to the bulling manager so as to be applied to the associated charges. Any over payments will be reimbursed to you or your insurance company if applicable. Any services not covered or coverage reductions by your insurance will be the patient's responsibility. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims with be treated as uncovered services and you will be expected to cover them in a timely manner.

FINANCIAL POLICY

Payment is due at the time of service unless prior arrangements have been made with the business office manager. I hereby agree to pay for services rendered as charges are incurred. In the event of default I will be required to pay legal interest on my debt along with collection costs (35% of the debt) and reasonable attorney fees as may be required to collect on my account.

RECEIPT OF NOTICE OF PRIVACY OF PRACTICES

I hereby confirm that I have received a copy of Turley Chiropractic's NOTICE OF PRIVACY OF PRACTICES. I understand that it is my responsibility to familiarize myself with the contents of this notice.

I HAVE READ AND UNDERSTAND THESE POLICIES AND AGREE TO ABIDE BY THESE TERMS.

SIGNATURE _____ **DATE** _____

To be cost transparent, we are providing a list of services and supplies that are typically **NOT** covered by insurance. If you have any questions or concerns regarding coverage please do not hesitate to ask our front office.

SERVICES we provide NOT covered by insurance:

Cold Laser Therapy Treatment: $20/session

Prepaid Discount: 10 visits for $520 *for private pay patients only*

SUPPLIES typically NOT covered by insurance:

Tempur-Pedic Cloud Pillow: $115

Bamboo Deluxe Foam Pillow: $40

Posture Pump: $85, $125

Back Brace: $65

Neck Brace: $75

Curve Corrector: $35

Tens Unit: $45

BioFreeze: $11, $14

Electrodes: $5/pack

Ice Packs: $8, $12, $20

Ice Pack Sleeve: $3, $4

**A $35 no show fee will be applied to any appointments missed or cancelled with less than 24 hours notice*

Please initial below that you understand that you will be charged for any of the above reference services or supplies ONLY if you request them.

PATIENT INITIALS HERE: _____