New Patient Application

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

Name:_____ Today's Date:_____

Preferred Name: _____ Birthdate: ____/____/____ Age:_____

Address:_____

City/State/Zip:_____ Email:_____

Phone: Home:_____ Work:_____ Cell:_____

Status: Married / Widow / Divorced / Single Social Security #: _____

Who may we thank for referring you? _____

Occupation: _____

Employers name: _____ Phone: _____

Spouse's name: _____ Phone:_____

Spouse's employer:_____ Phone:_____

Children's names & ages:_____

Emergency Contact: _____ Phone: _____ Other: _____

Favorite hobbies or interests: _____

Your Prior Doctor of Chiropractic: _____

City, State: _____ Approximate date of last Chiropractic treatment: _____

Chiropractic adjusting techniques you've had success with: _____

General Practitioner name: _____

Phone:_____ City, State: _____

Please rate 1 (poor) to 10 (excellent) the quality of healthcare you feel you receive from your GP:

_____

Other Specialists you are currently under care with:

Name: _____ Phone:_____

Name: _____ Phone:_____

Name: _____ Phone:_____

Method of payment for first visit

____ Cash ____ Check ____ Credit Card

Person Responsible for payment:

Name: _____

Phone Number:_____

Address: _____

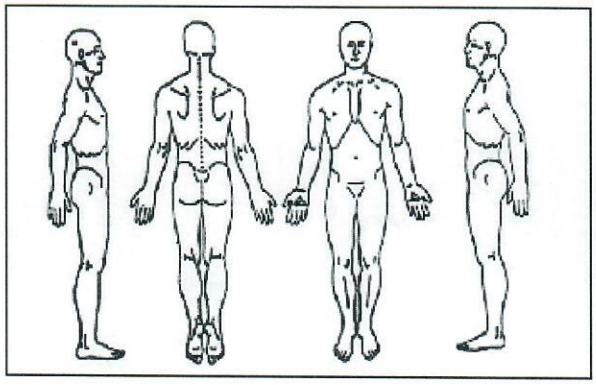
City:_____

State/Zip:_____

Do you have Health (crisis) Insurance? Y N

Insurance Company: _____

Mark Area(s) of Health Concerns:



Health reasons for consulting our office:

1._____ 2. _____

3._____ 4. _____

Have you had same or similar problem(s) before? ___Yes ___No

How long?_____ Please explain:_____

_____

Does this condition interfere with your: ____work _____sleep ___ daily routine_____
Father/Mother/Brother/Sister/Children, with similar problems?

_____

Is this the 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 Workmen's Compensation Insurances requires you to see in the first 90 Days? If so, who?_____

Other doctors who have treated this problem: _____

What treatments did you receive: _____

Medication(s) you currently take: _____

_____

Do you take supplements? Yes or No If yes, please list_____

Is there any chance you are pregnant? Yes____ No ____

What do you understand chiropractic care to be?_____

Do you know what a subluxation is? Yes or No If yes, please describe:

_____

Do you play any sports or exercise regularly? Yes or No If yes please describe_____

_____

Do you smoke? Yes or No If yes how many cigarettes/packs a day?_____

If any of the following have happened to you, give approximate dates & briefly describe injury:

Auto Accidents: _____ Motorcycle accidents: _____

Falls or other injuries: _____ Spinal or neck injuries: _____

Broken Bones: _____ Knocked unconscious: _____

Surgeries: _____ Health problems of parents: _____

Do you or have you had any of the following? Please write *C* of current and *P* for Past

___Angina ___Arthritis ___Asthma ___Allergies ___Carpal Tunnel ___Cancer ___Diabetes ___Emphysema ___Gout ___Heart Disease ___High Blood Pressure ___Kidney Disease ___Low Blood Pressure ___Migraines ___Numbness/tingling ___ Sciatica ___Seizures ___Sinus Problems ___Spinal curvature ___Stroke ___Thyroid disorder ___Tuberculosis ___Ulcers

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.

Parent or Guardian Signature: _____

Date: __/__/__

We believe that a clear definition of our policies will allow us both to concentrate on the big issue of regaining and maintaining your health…

APPOINTMENT POICY

In order to serve all our patients we ask that you call if you are unable to make your appointment. If you find yourself running late, please stop by the office and notify the receptionist and we will get you in for your visit as soon as possible. When you fail to notify our office, this leaves a time slot open that could otherwise be used to help someone else. Please help us help others. – Thank you

Payment Schedule

You have taken the first step on the path to optimal vibrant health. We take pride in delivering the finest in chiropractic care. The following payment options are available to help you handle your financial obligations.

- **Plan # 1 – CASH**
  Payment is due at the time of service, unless other payment arrangements have been made by the office.

- **Plan #2 – INSURANCE**
  Please present your insurance card today. We will call your insurance company for you to verify your coverage. If you have coverage for your chiropractic care, our office will submit claims for you. After your insurance company has been reached for benefit information a financial payment plan will be presented on your following visit. Until we have the completed necessary insurance information, you will be required to pay for your care on a cash basis.

- **Plan #3 – PERSONAL INJURY**
  You need to provide us with the accident report, your auto insurance, health insurance, and attorney if applicable. If the claim is a possible their party liability, please provide us with the other parties' insurance carrier information. Although my insurance or lawsuit may eventually pay for services rendered, if insurance or lawsuit does not pay, I understand that I am responsible to pay my balance in full.

Assignment of Benefits

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between the provider and patient. Our policy requires payment in full for all services render at the time of visit, unless other arrangements have been made with the office. If all charges are not paid when due, the undersigned agrees to pay cost of collections. This includes 33 1/3% attorney's fee or other collection agency fees, plus interest at the rate currently applicable by Virginia statue to judgments. It is agreed that any legal action for collections of monies due may be properly instituted in the courts of Virginia and Virginia Law shall apply.

I QUALIFY AND UNDERSTAND THE REQUIRMENTS OF PLAN(s) # _____.

Patient's or Guardians Signature: _____ Date: _____

Please Print Patient Name: _____ CA Initials: _____

Patient Authorization regarding chiropractic care provided in an "open adjusting" environment

It is the practice of this office to provide chiropractic care in an "open adjusting" environment. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care care discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal-law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open adjusting" environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on your care from our office or on your relationship with our staff.

Your signature indicates you authorization of this activity.

_____

Name (Printed) Signature Date

Cancellation/No-Show Policy for Massage Therapy/Muscle Work

It is the policy of this office that if you find it necessary to cancel or change an appointment you must allow at least 24 hours prior notice. Missed and canceled appointments without proper notification will result in a $30.00 cancellation fee.

If you are late for an appointment, it is necessary to still end at the appointed hour, so not to effect the appointment following you.

_____

Signature Date

Rosemont Chiropractic
397 Little Neck Rd
Building 3400 Suite 108
Virginia Beach, VA 23452

Patient Name: _____ D.O.B.:_____ Date:_____

PRIVACY NOTICE ACKNOWLEDGEMENT

We are concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have been offered a copy of Rosemont Chiropractic *Notice of Privacy Practices for Protected Health Information.*

_____ _____
Patient Name Printed Date

_____ _____
Patient Signature Authorized Provider Rep.

_____ _____
Personal Representative Printed Personal Rep. Signature

Description of personal representative's authority to act for the patient