

WELCOME

Patient Information

Name _____
Home Address _____
City, State, Zip _____
e-mail _____
 Single Married Divorced Separated Widow
Birth Date _____ Age _____
Sex: M F Soc. Sec. # _____
Occupation _____
Employer _____
Spouse's Name _____
Spouse's Birth Date _____
Spouse's Employer _____

Whom may we thank for referring you? _____

Insurance

Primary Insurance Co. _____
Is patient covered by additional insurance? Yes No
Secondary Insurance Co. _____
Please give us your insurance card(s) so we can make a copy.

Accident Information

Is condition due to an accident? Yes No
Type of accident? Auto Work
Date of accident _____
To whom have you made a report of your accident?
 Auto Insurance Employer Worker Comp. Other
Do you have an attorney representing you? Yes No
Name _____ Phone _____

Billing

Who is responsible for this bill? _____
I will be paying today by:
 Cash Check Credit Card Care Credit

Phone Numbers

Home _____ Cell _____ Work _____ Ext _____
Who may we contact in case of emergency? _____ Phone _____
Nearest relative not living with you _____ Phone _____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I understand that any insurance benefits which I may have are a contracted arrangement between myself and that insurance company. This office will assist in preparing notes, billing receipts and informational reports as needed to aid in insurance payment/ reimbursement. I realize that this office is not responsible to negotiate disputed benefits for me.

I am choosing to be treated, for today and all my future visits at this office, through the use of various types treatment which may include chiropractic manipulations, active release technique, acupuncture, rehabilitation, diagnostic tests and several types of physiological modalities (physical therapy). I realize there is no guarantee of results, and have been informed that some risk of treatment do exist. These risks could include, but are not limited to: sprains, dislocation, fractures, strokes, and disk injury. While I do expect my doctor to use his/her best judgment to choose the most appropriate care for my condition, I agree that the doctor cannot foresee every possible complication or risk which could arise in my treatment.

In order to provide a continuum of care, this office will notify your primary care physician of treatment/ medical findings as deemed necessary.

My signature below signifies that I completely understand and agree to all of the above statements, and give my consent for treatment. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature: _____ Date: _____

Witness: _____ Date: _____

Medical History Information

Last Name:					
First Name:			Middle:		
Medical Care Information					
Do You Have a Family Doctor?: <input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Doctor:					
Address:		City:		State:	ZIP Code:
Date of last Visit: / /			Date of last exam: / /		
Do You Have a Family Chiropractor?: <input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Chiropractor:					
Address:		City:		State:	ZIP Code:
Date of last Visit: / /			Date of last exam: / /		
Have you had surgeries in the last 5 Years: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Last Surgery Date:					
Have you had any other surgeries: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when:					
Reason for Surgery:					
Present illness /Conditions:					
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease	
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Seizures
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> S.T.D's
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Ulcer	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Polio	
<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Pregnant- how far_____	
Other:					
Family History of illness:					
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease	<input type="checkbox"/> STD'S	
<input type="checkbox"/> Allergies	<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Polio
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diverticulitis
Other:					
Type of Cancer: <input type="checkbox"/> Breast <input type="checkbox"/> Lung <input type="checkbox"/> Other:					
Social History:					
Alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per week?		Cigarettes? <input type="checkbox"/> No <input type="checkbox"/> Yes Packs per day?		Caffeine? <input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per day?	
				Exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes Hours per week? (circle one) Light / Moderate / Strenuous	
Misc.:					

Signature: _____

Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

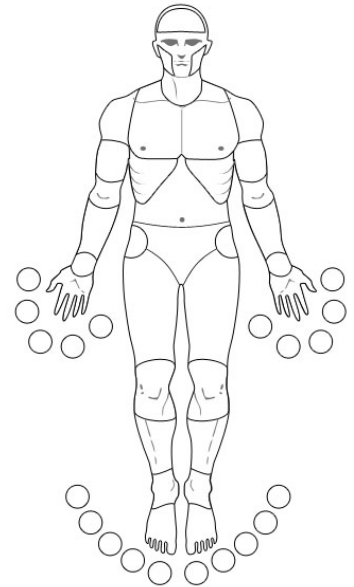
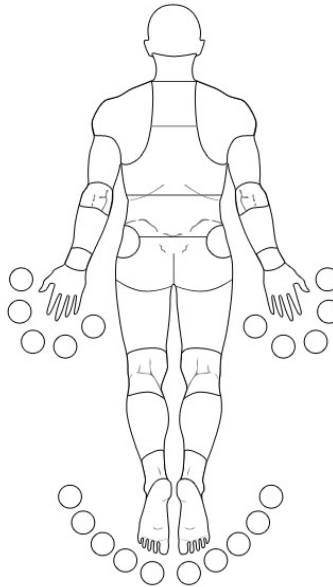
CURRENT COMPLAINTS

Patient's Name: _____

Date: _____

Please indicate the current complaints you are experiencing by marking the areas on the image below and providing details using the sections that follow. Start with the area that bothers you the most.

1. Headaches
2. Neck
3. Upper back
4. Mid Back
5. Lower Back
6. Hip
7. Buttock
8. Shoulder
9. Arm
10. Elbow
11. Forearm
12. Wrist
13. Hand
14. Fingers
15. Leg
16. Knee
17. Calf
18. Shin
19. Ankle
20. Foot
21. Toes
22. Chest
23. Ribs
24. Abdomen
25. Pelvis/Groin



Area of Complaint	List first area from above that bothers you the most:		
Location	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center		
Rate your pain	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)		
How often do you feel pain?	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%		
Pain type	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Burning		
How bad is your pain?	<input type="checkbox"/> Mild <input type="checkbox"/> Mild to Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate to Severe <input type="checkbox"/> Severe		
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing		
What makes it worse?	<input type="checkbox"/> Movements <input type="checkbox"/> Bending <input type="checkbox"/> Twisting <input type="checkbox"/> Weight Bearing <input type="checkbox"/> Movements <input type="checkbox"/> Neck flexion <input type="checkbox"/> Sneezing <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Chewing <input type="checkbox"/> Yawning <input type="checkbox"/> Opening mouth <input type="checkbox"/> Closing mouth <input type="checkbox"/> Range of motion <input type="checkbox"/> pushing/pulling <input type="checkbox"/> Lifting <input type="checkbox"/> Watching T.V. <input type="checkbox"/> Reading <input type="checkbox"/> Working <input type="checkbox"/> Driving <input type="checkbox"/> Housework <input type="checkbox"/> Bright lights <input type="checkbox"/> Loud Noises		
Does the pain radiate/ shoot to any other locations?	Upper Body	<input type="checkbox"/> Head <input type="checkbox"/> Forehead <input type="checkbox"/> Back of head <input type="checkbox"/> Right side of head <input type="checkbox"/> Left side of head <input type="checkbox"/> Neck <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Right Eye <input type="checkbox"/> Left Eye <input type="checkbox"/> Face <input type="checkbox"/> Right Jaw <input type="checkbox"/> Left Jaw <input type="checkbox"/> Right Upper back <input type="checkbox"/> Left Upper back <input type="checkbox"/> Right Shoulder <input type="checkbox"/> Left Shoulder <input type="checkbox"/> Right Chest <input type="checkbox"/> Left Chest <input type="checkbox"/> Right Ribs <input type="checkbox"/> Left Ribs	
	Mid Body	<input type="checkbox"/> Right Mid back <input type="checkbox"/> Left Mid back <input type="checkbox"/> Right Lower back <input type="checkbox"/> Left Lower back <input type="checkbox"/> Right Hip <input type="checkbox"/> Left Hip <input type="checkbox"/> Right Buttock <input type="checkbox"/> Left Buttock <input type="checkbox"/> Groin <input type="checkbox"/> Right Arm <input type="checkbox"/> Left Arm <input type="checkbox"/> Right forearm <input type="checkbox"/> Left forearm <input type="checkbox"/> Right hand <input type="checkbox"/> Left hand <input type="checkbox"/> Right fingers <input type="checkbox"/> Left fingers	
	Lower Body	<input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh <input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Calf <input type="checkbox"/> Left Calf <input type="checkbox"/> Right Toes <input type="checkbox"/> Left Toes <input type="checkbox"/> Right Foot <input type="checkbox"/> Left Foot <input type="checkbox"/> Right Toes <input type="checkbox"/> Left Toes	
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing		
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate		
Associated with	<input type="checkbox"/> Dizziness <input type="checkbox"/> Nausea <input type="checkbox"/> Visual Problems <input type="checkbox"/> Ringing/Buzzing ears <input type="checkbox"/> Bright light <input type="checkbox"/> Sensitivity <input type="checkbox"/> Loss of balance		
Comments			

Area of Complaint	List second area from above that bothers you the most:	
Location	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center	
Rate your pain	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)	
How often do you feel pain?	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%	
Pain type	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Burning	
How bad is your pain?	<input type="checkbox"/> Mild <input type="checkbox"/> Mild to Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate to Severe <input type="checkbox"/> Severe	
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing	
What makes it worse?	<input type="checkbox"/> Movements <input type="checkbox"/> Bending <input type="checkbox"/> Twisting <input type="checkbox"/> Weight Bearing <input type="checkbox"/> Movements <input type="checkbox"/> Neck flexion <input type="checkbox"/> Sneezing <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Chewing <input type="checkbox"/> Yawning <input type="checkbox"/> Opening mouth <input type="checkbox"/> Closing mouth <input type="checkbox"/> Range of motion <input type="checkbox"/> pushing/pulling <input type="checkbox"/> Lifting <input type="checkbox"/> Bright lights <input type="checkbox"/> Loud Noises <input type="checkbox"/> Watching T.V. <input type="checkbox"/> Reading <input type="checkbox"/> Working <input type="checkbox"/> Driving <input type="checkbox"/> Housework	
Does the pain radiate/ shoot to any other locations?	Upper Body	<input type="checkbox"/> Head <input type="checkbox"/> Forehead <input type="checkbox"/> Back of head <input type="checkbox"/> Right side of head <input type="checkbox"/> Left side of head <input type="checkbox"/> Neck <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Right Eye <input type="checkbox"/> Left Eye <input type="checkbox"/> Face <input type="checkbox"/> Right Jaw <input type="checkbox"/> Left Jaw <input type="checkbox"/> Right Upper back <input type="checkbox"/> Left Upper back <input type="checkbox"/> Right Shoulder <input type="checkbox"/> Left Shoulder <input type="checkbox"/> Right Chest <input type="checkbox"/> Left Chest <input type="checkbox"/> Right Ribs <input type="checkbox"/> Left Ribs
	Mid Body	<input type="checkbox"/> Right Mid back <input type="checkbox"/> Left Mid back <input type="checkbox"/> Right Lower back <input type="checkbox"/> Left Lower back <input type="checkbox"/> Right Hip <input type="checkbox"/> Left Hip <input type="checkbox"/> Right Buttock <input type="checkbox"/> Left Buttock <input type="checkbox"/> Groin <input type="checkbox"/> Right Arm <input type="checkbox"/> Left Arm <input type="checkbox"/> Right forearm <input type="checkbox"/> Left forearm <input type="checkbox"/> Right hand <input type="checkbox"/> Left hand <input type="checkbox"/> Right fingers <input type="checkbox"/> Left fingers
	Lower Body	<input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh <input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Calf <input type="checkbox"/> Left Calf <input type="checkbox"/> Right Toes <input type="checkbox"/> Left Toes <input type="checkbox"/> Right Foot <input type="checkbox"/> Left Foot <input type="checkbox"/> Right Toes <input type="checkbox"/> Left Toes
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing	
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate	
Associated with	<input type="checkbox"/> Dizziness <input type="checkbox"/> Nausea <input type="checkbox"/> Visual Problems <input type="checkbox"/> Ringing/Buzzing ears <input type="checkbox"/> Bright light <input type="checkbox"/> Sensitivity <input type="checkbox"/> Loss of balance	
Comments		

Area of Complaint	List third area from above that bothers you the most:	
Location	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center	
Rate your pain	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)	
How often do you feel pain?	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%	
Pain type	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Burning	
How bad is your pain?	<input type="checkbox"/> Mild <input type="checkbox"/> Mild to Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate to Severe <input type="checkbox"/> Severe	
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing	
What makes it worse?	<input type="checkbox"/> Movements <input type="checkbox"/> Bending <input type="checkbox"/> Twisting <input type="checkbox"/> Weight Bearing <input type="checkbox"/> Movements <input type="checkbox"/> Neck flexion <input type="checkbox"/> Sneezing <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Chewing <input type="checkbox"/> Yawning <input type="checkbox"/> Opening mouth <input type="checkbox"/> Closing mouth <input type="checkbox"/> Range of motion <input type="checkbox"/> pushing/pulling <input type="checkbox"/> Lifting <input type="checkbox"/> Bright lights <input type="checkbox"/> Loud Noises <input type="checkbox"/> Watching T.V. <input type="checkbox"/> Reading <input type="checkbox"/> Working <input type="checkbox"/> Driving <input type="checkbox"/> Housework	
Does the pain radiate/ shoot to any other locations?	Upper Body	<input type="checkbox"/> Head <input type="checkbox"/> Forehead <input type="checkbox"/> Back of head <input type="checkbox"/> Right side of head <input type="checkbox"/> Left side of head <input type="checkbox"/> Neck <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Right Eye <input type="checkbox"/> Left Eye <input type="checkbox"/> Face <input type="checkbox"/> Right Jaw <input type="checkbox"/> Left Jaw <input type="checkbox"/> Right Upper back <input type="checkbox"/> Left Upper back <input type="checkbox"/> Right Shoulder <input type="checkbox"/> Left Shoulder <input type="checkbox"/> Right Chest <input type="checkbox"/> Left Chest <input type="checkbox"/> Right Ribs <input type="checkbox"/> Left Ribs
	Mid Body	<input type="checkbox"/> Right Mid back <input type="checkbox"/> Left Mid back <input type="checkbox"/> Right Lower back <input type="checkbox"/> Left Lower back <input type="checkbox"/> Right Hip <input type="checkbox"/> Left Hip <input type="checkbox"/> Right Buttock <input type="checkbox"/> Left Buttock <input type="checkbox"/> Groin <input type="checkbox"/> Right Arm <input type="checkbox"/> Left Arm <input type="checkbox"/> Right forearm <input type="checkbox"/> Left forearm <input type="checkbox"/> Right hand <input type="checkbox"/> Left hand <input type="checkbox"/> Right fingers <input type="checkbox"/> Left fingers
	Lower Body	<input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh <input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Calf <input type="checkbox"/> Left Calf <input type="checkbox"/> Right Toes <input type="checkbox"/> Left Toes <input type="checkbox"/> Right Foot <input type="checkbox"/> Left Foot <input type="checkbox"/> Right Toes <input type="checkbox"/> Left Toes
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing	
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate	
Associated with	<input type="checkbox"/> Dizziness <input type="checkbox"/> Nausea <input type="checkbox"/> Visual Problems <input type="checkbox"/> Ringing/Buzzing ears <input type="checkbox"/> Bright light <input type="checkbox"/> Sensitivity <input type="checkbox"/> Loss of balance	
Comments		

Patient's Signature

Financial Policy

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, Care Credit, Discover, MasterCard, or Visa. We will gladly discuss your proposed treatment and answer any questions relating to your insurance/ payment. Please review the following:

PATIENTS WITHOUT INSURANCE

We request that all visits be paid in full at the time of service. Because we offer a claim filing discount, we will only provide a simple receipt and **will not** file your insurance at a later date.

GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic or other services offered in our office, although most policies do provide coverage. The amount they pay and the services they cover varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you get your full benefit. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays.

If we are participating providers for your insurance company, we have contracted to accept the U.C.R. (usual, customary, and reasonable) rate. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance (U.C.R.) determined by each carrier. However, if the insurance company determines that any service is "non-covered" or was "not medically necessary" or determines that you were not covered at the time of service, you are responsible in full for the service(s). Keep in mind the insurance company may not have your spine in their best interest, but the doctor uses his medical judgement about the care that is needed. **We suggest that you check your insurance policy coverage.**

"ON THE JOB" INJURY (Worker's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. Florida is a no fault state. We will bill (accept assignment) from your auto insurance, which usually covers 80%. We may accept Letter of Protection or Doctor's Lien from an attorney, bill your medical insurance, or collect cash at the time of service to cover any unpaid balance. If we accept a Letter of Protection or Doctor's Lien from an attorney, we will wait for the balance of payment at the time of settlement as long as you remain an active patient. If we bill your standard health insurance plan, you will be responsible for all co-pays and deductibles as they are incurred. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to **(six)** months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

MEDICARE

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, acupuncture, active release technique, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office files the forms for Medicare at no charge.

- We offer an interest free (up to 18 months) payment plan. Please ask for details.
- Returned checks are subject to a minimum additional fee of \$30.00.
- Charges may also be made for broken appointments and appointments cancelled without 24 hours notice.
- Please bring in any checks/EOB that your insurance company mails you directly so we may apply it to your account.

I have read and understand the above payment policy. I understand that I am personally responsible for the total amounts due to Lawrence I. Teixeira, DC, PA for their services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Lawrence I. Teixeira, DC, PA for all costs of such collections efforts, including, but not limited to, all court costs and all attorney fees.

Patients Signature (or guardian or parent if a minor)

Date