REGISTRATION

SOUTH RIDING FAMILY CHIROPRACTIC CENTER

4229 Lafayette Center Drive, Suite 1900
Chantilly, VA 20151

CONFIDENTIAL

Date_________________ Contact Number ___________________

Patient ____
Last Name First Name Initial

Email address____

Street Address____

City________________________________ State_______________________ Zip _____________________________

Sex M F Age__________ Birthdate______________ Single Married Widowed Separated Divorced

Primary Language _______________ Race__________________ Ethnicity___________________________

Patient Employed By ____

Business Address ____

Occupation_________________________________ Business Phone _______________________________________

Spouse (or responsible party) Name____________________________________ Birthdate _______________________

Spouse Employed By ____

Business Address ____

Occupation_________________________________ Business Phone_______________________________________

Who is responsible for this account?________________________________ Relationship to Patient _________________

Social Security # ______________________________ Spouse's Social Security # ________________________________

Do you have Medical Insurance? No Yes ⇒ If yes,

Name of Primary Insurer ____

Contact # _________________________ Group # ________________________ Subscriber #_________________

Medicare Medicaid Claim ID # ________________________________

In case of emergency, who should be notified? ________________________________ Phone______________________

How did you learn of our practice? ____

ASSIGNMENT AND RELEASE

I, (the undersigned), have insurance coverage with ____
Name of Insurance Company

And assign directly to Dr.____ all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

____ ______________________________
Signature of Insured / Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made to me or on my behalf to Dr.__________________________________
For any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

____ ______________________________
Beneficiary Signature Date

South Riding Family Chiropractic Center
4229 Lafayette Center Drive
Suite 1900
Chantilly, VA 20151
(703) 327-9773

HEALTH CARE AUTHORIZATION FORM

Patient's Name ____

Patients SS# ___________________________ Date of Birth ____________

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **SOUTH RIDING FAMILY CHIROPRACTIC CENTER** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- ❑ I give permission to **South Riding Family Chiropractic Center** to use my address, phone number and clinical records to contact me with birthday cards, related reminder cards, and information about treatment alternatives or other health related information.

- ❑ I give permission to **South Riding Family Chiropractic Center** to place my name on the referral thank you board and/or place my child's picture on the well adjusted kids wall.

- ❑ By signing this form you are giving South Riding Family Chiropractic Center permission to use and disclose your protected health information in accordance with the directives listed above.

____________________	______________________	___________
Print Name	Signature (or parent if a minor)	Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

____________________________________ ____________

Patient Signature Date

Case History

Symptoms

Reason for visit________________________________When did you first notice the symptoms?____________________________
Is this condition getting progressively worse?____
Where specifically is the problem(s) located?____
Which activities are difficult to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Other
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Cramps ☐ Tingling ☐ Stiffness ☐ Swelling ☐ Other
Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10
Is the pain constant or does it come and go?____
What treatment have you already received for your condition?
☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Other
Name and address of other doctor (s) who have treated you for your condition:
____

Health History

Check only those conditions which are applicable:

☐ AIDS/HIV	☐ Cataracts	☐ Hepatitis	☐ Osteoporosis	☐ Suicide Attempt
☐ Alcoholism	☐ Chemical Dependency	☐ Hernia	☐ Pacemaker	☐ Thyroid Problems
☐ Allergy Shots	☐ Chicken Pox	☐ Herniated Disc	☐ Parkinson's Disease	☐ Tonsillitis
☐ Anemia	☐ Depression	☐ Herpes	☐ Pinched Nerve	☐ Tuberculosis
☐ Anorexia	☐ Diabetes	☐ High Cholesterol	☐ Pneumonia	☐ Tumors, Growth
☐ Appendicitis	☐ Emphysema	☐ Kidney Disease	☐ Polio	☐ Typhoid Fever
☐ Arthritis	☐ Epilepsy	☐ Liver Disease	☐ Prostate Problems	☐ Ulcers
☐ Asthma	☐ Fractures	☐ Measles	☐ Prosthesis	☐ Vaginal Infections
☐ Bleeding Disorders	☐ Glaucoma	☐ Migraine Headache	☐ Psychiatric Care	☐ Venereal Disease
☐ Breast Lump	☐ Goiter	☐ Miscarriage	☐ Rheumatoid Arthritis	☐ Whooping Cough
☐ Bronchitis	☐ Gonorrhea	☐ Mononucleosis	☐ Rheumatic Fever	☐ Other____________
☐ Bulimia	☐ Gout	☐ Multiple Sclerosis	☐ Scarlet Fever	__________________
☐ Cancer	☐ Heart Disease	☐ Mumps	☐ Stroke	__________________

Date of last exams____
(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No
List any types of surgeries which you have had and the dates which they occurred:
____
____
Please list all medications you are currently taking:____
Allergies:____

Daily Habits

What type of exercise do you perform on a daily basis? ☐ None ☐ Moderate ☐ Heavy
What do your daily work habits include? (ex. sitting, standing, light labor, heavy labor, computer work)
____
What vitamins do you currently take?____
What kind of other nutritional supplements do you take (if any)? ____
Do you smoke? ☐ No ☐ Yes How much per day?____
How much coffee or caffeinated beverages do you consume on a daily basis?_____________________________

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X____
SIGNATURE OF PATIENT (or parent if a minor) DATE

FAMILY HISTORY

MANY HEALTH RELATED PROBLEMS ARE A RESULT OF HEREDITY TRAITS, SPINAL WEAKNESS OR ENIVROMENTAL FACTORS. THUS, INFORMATION ABOUT YOU FAMILY MEMBERS WILL PROVIDE US WITH A MORE COMPLETE PICTURE OF YOU.

HEALTH PROBLEM	FAMILY HISTORY
ALCOHOLISM IN FAMILY	YES/NO
DIABETES	YES/NO
CANCER	YES/NO
HEART DISEASE	YES/NO
PHYSICAL HANDICAPS	YES/NO
ASTHMA	YES/NO

ON THE LINES BELOW, PLEASE LIST ANY CHIROPRACTIC PHYSICIANS, MEDICAL PHYSICIANS, DENTISTS, OR OTHER SPECIALISTS YOU HAVE CONSULTED IN THE LAST YEAR FOR THIS OR ANY OTHER CONDITION. PLEASE LIST THEIR SPECIALTY AND BRIEFLY DESCRIBE THEIR DIAGNOSIS AND TREATMENT.

DOCTOR ______________________________ SPECIALTY __________
ADDRESS ____
DIAGNOSIS ____
TREATMENT ____

DOCTOR ______________________________ SPECIALTY __________
ADDRESS ____
DIAGNOSIS ____
TREATMENT ____

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of **South Riding Family Chiropractic Center**. The written notice must contain the following information:

Your name, social security number and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
the date of your request; and your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by **South Riding Family Chiropractic Center** for its own use/disclosure of PHI.
(Minimum necessary standards apply.)

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, **South Riding Family Chiropractic Center** will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

- A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU

______________________	________________________	____________
Print Name	Signature (or parent if a minor)	Date

South Riding Family Chiropractic Center

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. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

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

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

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra 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 a 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 a major interference to 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 above statements.
(print name)

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)

Consent to evaluate and adjust a minor child

I, ____ being the parent or legal guardian of

_____________________________________ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: ______________________________________

____ __________________________
(signature) (date)

South Riding Family Chiropractic Center

X-Ray Consent Form

The doctor has explained that the purpose of the x-rays about to be taken is to analyze the spine for vertebral subluxations and to determine the appropriateness of chiropractic spinal adjustments. If the doctor discovers a non-chiropractic "unusual finding" when reviewing this x-ray, I will be informed. I then must determine if I should seek the services of an additional health care provider for advice, diagnosis, or treatment for the unusual finding. I understand that seeking advice from another type of health care provider should not interfere with the subluxation corrective care provided by this office.

I fully understand the above and consent to chiropractic spinal x-rays.

Patient's Signature:___________________________________ Date_________________________