



SECTION 1.

ABOUT YOU

Today's Date: ____ / ____ / ____

Name: (Last) _____ (First) _____ (Mid. Init.) _____

Birthdate: ____ / ____ / ____ Age: _____ Gender: Male Female Social Security #:* _____ - _____ - _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ E-mail Address: _____

Phone #:** Home _____ Cell _____ Work _____

Employer: _____ Occupation: _____

Status: Minor Single Married Partnered Divorced Separated Widowed

If Married, Spouse's Name: _____ # of Children: _____

Emergency Contact: _____ Phone #: _____

Whom may we thank for referring you? _____

**Optional **Check best contact number*

SECTION 2.

PAYMENT (select one)

Insurance Insurer's Name (if other than self): _____ Insurer's DOB: ____ / ____ / ____

Primary: _____ Policy #: _____ Secondary: _____ Policy #: _____

Auto/Personal Injury Auto Insurance Carrier: _____ Policy #: _____

Claim #: _____ Adjuster's Name: _____

Adjuster's Ph. #: _____ Adjuster's Fax #: _____

Attorney Name (If Applicable): _____ Attorney Phone #: _____

Self-Pay **Other (Please Specify)** _____

SECTION 3.

HEALTH HISTORY

Primary Care Physician: _____ Phone #: _____

Are you Taking Any Medications? Yes No If yes, please list _____

Have you ever had an MRI of your spine? Yes No If yes, when _____

Do you have or ever had any of the following diseases or conditions? (mark: **y** for yes **n** for no)

<input type="checkbox"/> Alcohol/drug abuse	<input type="checkbox"/> Congenital heart defect	<input type="checkbox"/> Frequent neck pain	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Sciatica
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes/tuberculosis	<input type="checkbox"/> Heart attack/stroke	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Severe/frequent headaches
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Leg/Arm Pain	<input type="checkbox"/> Shingles
<input type="checkbox"/> Artificial bones/joints	<input type="checkbox"/> Dislocations	<input type="checkbox"/> Heart surgery/pacemaker	<input type="checkbox"/> Lower back problems	<input type="checkbox"/> Sinus problems
<input type="checkbox"/> Artificial valve	<input type="checkbox"/> Emphysema/Glaucoma	<input type="checkbox"/> Herniated Disc	<input type="checkbox"/> Mitral valve prolapse	<input type="checkbox"/> Snoring
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fainting/seizures/epilepsy	<input type="checkbox"/> High/low blood pressure	<input type="checkbox"/> Psychiatric diagnoses	<input type="checkbox"/> Ulcer/colitis
<input type="checkbox"/> Cancer/Chemotherapy	<input type="checkbox"/> Fractures	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Venereal disease

List any other serious medical condition(s) that we should know about: _____

List any past serious accidents or surgeries and include the dates: _____

List allergies: _____

Do you exercise? Yes _____ times/day No What exercise activities do you do? _____

Do you: • smoke? Yes _____ times/day No • drink alcohol? Yes _____ times/week No • drink coffee? Yes _____ cups/day No

Do you take supplements (i.e. vitamins, minerals, herbs)? List them: _____

FOR WOMEN: Have children? Yes No Taking birth control? Yes No Pregnant? Yes No Nursing? Yes No



SECTION 4.

REASON FOR VISIT

The reason for this visit is a result of Work Auto Trauma Chronic Other (Explain): _____
Please describe the pain and its location: _____
When did the condition begin? _____ This condition is: Constant Intermittent Activity related
Condition is interfering with: Work Sleep Hobbies Daily routine If so please explain: _____
What activities aggravate your symptoms? _____ Condition getting worse? Yes No
Is there anything, which has relieved your symptoms? Yes No (Describe) _____
Have you experienced this condition before? Yes No If so please explain: _____
Who have you seen for this? _____
What did they do? _____ How did you respond? _____
Are there activities you cannot do as a result of your problem/pain? Yes No (Describe) _____

SECTION 5.

CHIROPRACTIC HISTORY (if applicable)

What is your goal here at Bethesda Spine & Posture?

Have you ever been treated by a chiropractor before? Yes No If so, whom? _____ When? _____

Did your previous chiropractor take before and after x-rays? Yes No

Please circle the number corresponds with your pain today overall. 1= No pain 10= Worst pain imaginable
1 2 3 4 5 6 7 8 9 10

Please circle the number corresponds with your pain at its worst. 1 2 3 4 5 6 7 8 9 10

Is there any time during the day that you have no pain? Yes No

Do you ever "pop or crack" your own neck or back? Yes No

Do you snore at night? Yes No Do you ever experience numbness or tingling in your hands/feet? Yes No

Do your feet ever bother you? Yes No Do you sometimes feel like one leg is longer than the other? Yes No

SECTION 6.

RADIOGRAPH CONSENT, APPOINTMENT POLICY, AUTHORIZATION FOR TREATMENT

I _____ hereby give my consent to allow Bethesda Spine & Posture and it's representatives as deemed by the examining physician to take radiographs (x-rays) of my spine and/or extremities

For Women: I also hereby declare that to my knowledge I am not pregnant _____ (Initial)

Signature of Patient or Guardian of said Minor _____ Date _____

Missed appointments without prior notification will result in a \$25.00 cancellation fee. We apologize for any inconvenience this may cause, but each patient's time with the doctor/therapist is valuable. If you need to reschedule your appointment, kindly give us a courtesy phone call, so we are able to open up the timeslot for other patients.

Signature of Patient or Guardian of said Minor _____ Date _____

I authorize and agree to allow the doctor and/or physical therapist to examine and treat me for the purpose of postural and structural restoration of normal biomechanical, neurological function, and reduction of pain.

The doctor and/or physical therapist will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the medical and spinal structural conditions diagnosed at this clinic.

I authorize the assignment of all insurance benefits to be directed to the doctor and/or physical therapist for all services rendered.

Signature of Patient or Guardian of said Minor _____ Date _____



SECTION 7.

NOTICE OF PRIVACY PRACTICES

The following authorizes Bethesda Spine & Posture to use and/or disclose protected health care information in accordance with the following specific authorizations:

I give permission to Bethesda Spine & Posture to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective healthcare information during the course of my treatment. Should I need to speak with the doctor/physical therapist in private, the doctor/physical therapist will provide a private room for these conversations.

By signing the following you are giving Bethesda Spine & Posture permission to use and disclose your protected health information in accordance with the directives listed in the "Authorization for Treatment" section. Information you provide may be used for:

- Treatment
- Payment
- Appointments

_____ (Initial) I authorize Bethesda Spine & Posture to notify me of appointments by email or text appointment reminders, per my request. And I authorize Bethesda Spine & Posture to email my x-rays and medical records, upon my request. I understand that records sent through unencrypted email pose a security risk, but it is my requested method.

_____ (Initial) I understand and have been provided with a notice of information practices that provides me with 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 care information for directory purposes
- The right to request restrictions as to how my health care information may be used or information may be used or disclosed in this office to carry out treatment, payment, or health care operations

Signature of Patient or Guardian of said Minor _____ Date _____

SECTION 8.

PAYMENT POLICY, INSURANCE POLICY

In order to keep our fees from rising and at the same time keep up with the monumental expenses of bookkeeping and billing services, we have opted to offer our patients these payment policies.

1. Payment is expected at the time services are rendered. Our office accepts cash, Visa, Mastercard, Discover, American Express, and checks.
2. Non-insured patients are expected to make payments in full on the day the service is rendered, unless definite arrangements have been made with the doctor in advance.
3. Patients with insurance are expected to pay their patient portion of the total fee not covered by their insurance on the day of service. This "patient portion" is ONLY an estimated dollar amount.
4. At your request, the doctor will discuss the charges with you before care begins.

We bill patients on a monthly basis. All accounts not paid within 90 days will automatically be put through to an outside collections' agency, which may affect your credit. In case of financial difficulty, please let us know so that a manageable payment schedule can be worked out.

Signature of Patient or Guardian of said Minor _____ Date _____

1. You are considered to be a cash patient until our office qualifies your coverage to determine the extent of benefits under your policy. As a COURTESY, our office will file your claim with your insurance company, and initiate correspondence with the purpose of getting you the maximum coverage your insurance will allow; however, the payment is ultimately your responsibility.
2. All deductible payments must be made prior to insurance submittal. Please contact your insurance company to verify your coverage.
3. All co-payments must be paid in full at the time of service.
4. Should you discontinue care for any reason other than discharge by the doctor, any and all balances due will become immediately payable in full, regardless of any claims submitted.
5. This office does not promise that insurance company will reimburse you for the usual and customary charges submitted by this office, nor will we enter into any dispute with an insurance company over the amount of reimbursement.

Signature of Patient or Guardian of said Minor _____ Date _____