total bodywork
CHIROPRACTIC

Chiropractic Patient Update

Please complete Parts A & C in all cases. Part B should be completed only if the information has changed since you were last in our office. If it has been longer than 3 months since you have seen the doctor, you will be a re-exam patient. **If it has been over one year since you have seen the doctor, you will not be adjusted and new X-Ray's will be taken.**

PART A

Name:		Date:
Address:		
City:	State:	Zip:
Home Ph.:	Work Ph.:	Cell Ph.:
Email:		
Purpose of this appointment:		
Is this the same problem you were originally under care for? Y N		
If yes, are there any additional symptoms?		
Other doctors seen for this condition?		
What medications or drugs are you taking?		

PART B

Occupation:	Employer:	
Employer's Address:		
City:	State:	Zip:
Spouse:	Spouse's Employer:	

PART C

Name: AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Signature:	Date:

What is your major symptom?
If this is a recurrence, when was the first time you noticed this problem?
How did it originally occur?
Has it become worse recently? Yes No Same Better Gradually Worse
How frequent is the condition? Constant Daily Intermittent Night Only
How long does it last? All Day Few Hours Minutes
Are there any other unrelated health problems? Y N If yes, describe:
Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing Other:
Is there anything you can do to relieve the problem? Y N If yes, describe:
What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting Other:
Have you had any broken bones? Y N If yes, please list and give dates:
List any major accidents you have had other than those that might be mentioned above:
To your knowledge, have you had any diseases, major illnesses or injuries not indicated on this form either in the past or present? Y N If yes, please explain:
WOMEN ONLY:Are you pregnant or is there any possibility you may be pregnant? Yes No Uncertain
What goals are you hoping to achieve with chiropractic care? (Please choose one) ☐ Pain Relief ☐ Pain Relief & Correction of Problem ☐ Pain Relief & Correction of Problem & Prevention of Future Problems ☐ I want to call when I want to get adjusted
Remarks:

Pain Severity Scale: Rate the severity of your pain by checking one box on the following scale

No Pain	1	2	3	4	5	6	7	8	9	10	Extreme Pain

Patient Signature:	Date:
Doctor's Signature:	Date:

total bodywork Policies

By signing below, you are acknowledging that you have read, understand and agree to the total bodywork policies.

- ADJUSTMENTS ARE NOT DONE ON THE FIRST VISIT and diagnostic tests may be performed off-site.
- I authorize total bodywork to send my x-rays for an outside read, if needed. I understand that by doing this I may incur a fee in the office or with the company performing the outside read. I agree to allow the third party to bill my insurance for this service or I will pay the fee this office incurs for this service.
- I understand the insurance coverage explained to me is NOT a guarantee of benefits, and I am responsible for any amount that my insurance company does not cover.
- If we can not verify benefits on your first visit because of problems with your insurance company, examples: offices closed, their computer is down, etc, you will be responsible to pay the cash price and you will be refunded any amount due on your second visit.
- Patients are required to purchase electrodes for passive therapy at $8 per set and that each set lasts approximately 10 to 15 uses.
- I understand that if I do not have insurance coverage or my insurance does not cover chiropractic or if I choose not to file on my insurance, I am responsible for the time of service discount cash prices which are as follows: Non-pregnant patients $235 (includes x-rays of 1 body region), pregnant patients $175, children $165 (approximately 7 & under)
- I understand that I am responsible for all charges incurred at total bodywork including but not limited to supplements, products, services, and the 'no-call - no-show' policy.
- We enforce a 'no-call - no-show' policy, any patient missing an appointment without calling to cancel or reschedule 24 hours prior to the appointment will be charged a $25 fee.
- Because there are many patients with headaches seen in this office, and I agree to turn my cell phone off or set it to silent when I am at total bodywork.
- I understand that I will be charged a $30 returned check fee each time a check is returned unpaid and that it may be electronically debited from my account.
- I understand that I will be charged $30 for any chargeback fees on credit card transactions.
- I understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 18%.
- Payment in full is due at the time services are rendered.
- I understand that original x-ray films cannot be released and copies will be charged at a minimum of $50 for 2-films. Pictures can be taken, by you, if you request but we will need advance notice so the films can be pulled and ready for your next visit.
- If you are a Medicaid patient, please be advised that we do not accept Medicaid. You will be a private pay or cash patient and responsible for all charges incurred at this office.
- I give permission to any of the total bodywork staff to leave messages at any of the phone numbers I have listed via voicemail or whomever answers. I also give permission for any correspondence from total bodywork to be mailed to my home address or email.
- If I have not been seen in the office for over 3-months, a re-exam will be performed.
- If a letter of excuse is needed for my work/school, I should request it at the time of check-in.
- Treatment is performed in an open environment, inadvertent disclosure may occur to surrounding patients. If you have a situation to discuss privately, please let us know.
- PLEASE NOTE: ADJUSTMENTS ARE NOT DONE ON THE FIRST VISIT

Patient Signature:	Date: