ChiropracticUSA

5909 Stanley Ave, Ste A
Carmichael, CA 95608
(916) 973-1661

PATIENT CONFIDENTIAL INFORMATION

Welcome to our Office! Please complete all the questions.

Full Name:			Date:
Address:		City/State/Zip:	
Work Phone:	Home Phone:	Cell Phone:	Email:
Birth Date: Age:		Social Security #:	
Marital Status: M W D S Please Circle		Drivers License #:	
Your Employer:		Occupation:	
Spouse's Name:		Occupation:	
Children's Names and Ages:			
Favorite Hobbies or Interests:			
Purpose of this Appointment:			
Major Fall or Accident Date:			
What Do You Believe is Wrong?			
Date Present Condition Occurred: Describe How:			
Method of Payment for First Visit: □ Cash □ Check □ Credit Card			

Have you had previous Chiropractic care? □ Yes □ No

Doctor's Name: _____

Who may we thank for referring you? _____

Have you had same or similar problem(s) before? □ Yes □ No If so, how long? _____

Is this the result of an auto or work injury? □ Yes □ No If so, when? _____

Father, mother, brother, sister, children with similar problem(s)? _____ If so, who? _____

Other doctors seen for this problem? _____

Surgeries you have had? _____

Medications you currently take? _____

Is there any chance you are pregnant? □ Yes □ No

Have you ever been diagnosed with cancer? □ Yes □ No If so, what kind? _____

Do you have health insurance? □ Yes □ No Name of company? _____

❑ I give authorization to check a minor patient. *Please fill out the Consent to Treat a Minor form*.

The above information is true and accurate to the best of my knowledge.

Patient Signature _____ Date: _____

(Please print) _____

Parent or Guardian Signature: _____ Date: _____

Chiropractic USA Financial Arrangement Policy

Chiropractic USA has varied payment plans to suit your financial position. We do not base your care on your insurance company and neither should you. Insurance coverage is usually for relief care and does not pay for the entirety of corrective care. In addition, most insurance companies have their own designated limitations. Our goal is to work with you as long as you have the commitment to complete the program you have agreed to and achieve your maximum health potential.

CASH

It is our policy that 100% of the first visit be paid at the time of service. The Doctor will advise you of the charges for services rendered. For patients on corrective or maintenance care programs, several payment options are available. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

ON THE JOB INJURY

All work injuries must be notified to your employer. Your employer will complete an accident report and you will complete a doctor's first report. Workers Compensation pays in full for non-litigated cases. Work injuries do not include corrective care. It is important to maintain all scheduled visits to ensure the success of your health and your case.

PERSONAL INJURY

It is important to remember that personal injuries require special documentation. Please be as specific as possible. Present your auto insurance policy and/or group insurance by your second visit. If an attorney is handling your case, please notify the financial department immediately. Remember, you are solely responsible for all services rendered.

PAYMENT IS EXPECTED AT TIME OF VISIT!

I understand that payment is required at time of service. Some medical insurance and credit cards are accepted. I understand and agree that health accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the chiropractic office may prepare billing forms to assist me in making collections from my insurance company. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in full. I also understand that if I terminate or suspend my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I further agree to pay all collections agency fees, court fees and other related costs incurred in collection of my account.

I authorize the release of medical records to the physician to whom I may be referred. I authorize the release of any medical information necessary to process insurance claims.

Method of payment: ☐ Cash ☐ Check ☐ Credit Card

Name of person responsible for payment: _____

Are you insured? ☐ Yes ☐ No Company: _____

Patient Signature: _____ Date: _____

Guardian or Spouse's Signature Authorizing Care: _____ Date: _____