Date_____ Acct #_____
(for office use only)

ALIGN CHIROPRACTIC WELLNESS CENTER, LLC

Personal Information

Name_____
Last First Middle Initial

DOB_____ Age_____ Social Security Number_____

Address_____

City _____ State _____ Zip Code_____

Gender ☐Male ☐ Female

Phone Number_____ ☐Home ☐Mobile ☐Work

Email_____

Would you like to receive appointment reminders via ☐Text message ☐Email

Marital Status ☐ Married ☐ Single ☐Widowed ☐ Divorced/Separated

Occupation _____ Employer_____

Referral Source ☐ Doctor ☐ Friend/Family ☐ Online ☐ Print Ad ☐ Other_____

Emergency Contact Name_____ Phone_____

Insurance Information

**Please provide your insurance card(s) and driver's license for verification

- Were you involved in an Auto Accident ☐Yes ☐No Workman's Comp ☐Yes ☐ No
  List Claim # as the ID #

Primary Insurance Company_____

ID #_____ Group #_____

Subscriber Name_____ DOB_____

Relationship to the subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

Are you covered by additional insurance ☐ No ☐ Yes, please complete the following

Secondary Insurance Company_____

ID #_____ Group #_____

Subscriber Name_____ DOB_____

Relation Ship to the subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

Patient History and Condition

Reason for visit_____

When did symptoms begin or accident occur_____

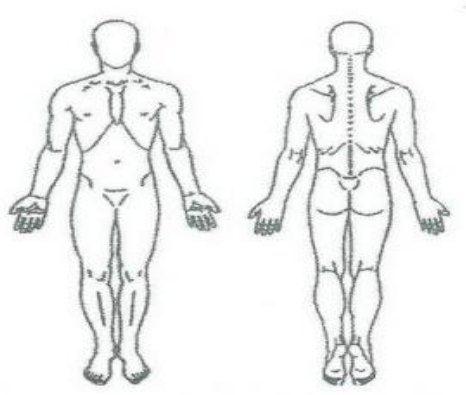
Frequency ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional

Type of Pain ☐ Sharp ☐ Dull ☐ Ache ☐ Burning ☐ Stiffness/Tightness ☐ Tingling ☐ Numb

Does the discomfort radiate/travel ☐ No ☐ Yes, Where _____

Is the complaint ☐ Improving ☐ Staying the same ☐ Worsening ☐ Changing ☐ Other _____

How would you rate your pain level on a scale of 1-10, 10 being the worst_____



On the body diagram to the right, please indicate the areas that are bothering you.

What have you tried to help the problem_____

- Was it effective ☐ No ☐ Yes

Have you had this problem in the past ☐ No ☐ Yes

Have you had recent tests or imaging ☐ No ☐ Yes, where_____

What activities are difficult to perform? ☐ Bending to tie shoes ☐ Lifting groceries ☐ Driving ☐Going up/down stairs ☐ Changing position ☐ Sleeping ☐ Sitting ☐ Walking ☐ Standing ☐ Other _____

Primary care physician/PCP _____ Phone Number _____

Have you consulted any health care professional for this condition? ☐ No ☐ Yes, Who _____

Have you been diagnosed with the following conditions? Check all that apply:

☐ Alcoholism
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Breast implants
☐ Breathing issue
☐ Cancer _____
☐ Depression
☐ Dementia
☐ Diabetes
☐ Food Sensitivities _____
☐ Fractures _____
☐ Gout
☐ Heart disease
☐ Hernia
☐ Herniated disc
☐ High blood pressure
☐ High cholesterol
☐ Immune disorder
☐ Kidney disease
☐ Migraine headaches
☐ Multiple sclerosis
☐ Osteoporosis
☐ Pacemaker
☐ Parkinson's Disease
☐ Pneumonia
☐ Prostate problem
☐ Prosthesis _____
☐ Psychiatric condition
☐ Rheumatoid arthritis
☐ STDs/STIs _____
☐ Stroke/TIA
☐ TBI/Concussion
☐ Thyroid problem
☐ Tumors/growths
☐ Ulcers
☐ UTIs
☐ Vaginal infection
☐ Other _____

Patient name _____ Date _____
Last name First name

Lifestyle

- Exercise ☐ None ☐ Moderate ☐ Daily
- Dietary Restrictions ☐ None ☐ Gluten ☐ Dairy ☐ Other_____
- Sleep ☐ Back ☐ Side ☐ Stomach ☐ Other_____
    - Hours of sleep ____ Do you feel rested ☐ No ☐ Yes
- Habits ☐ Alcohol ☐ Smoking ☐ Caffeine ☐ High stress

Medications	Vitamins/Supplements

Patient name _____ Date _____

Last name First name

Patient HIPAA Consent Form

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. In the future, we may contact you for appointment reminders, announcements and to inform you about our practice. I authorize the use of my full name for the purpose of greeting me, announcing me into a room or around the office in the presence of others. This is effective as of April 14, 2003 and remains in effect until further notice. I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. A more complete description can be requested.

Signature_____ Date_____

Insurance Policy

1. The privilege of insurance is conditional on receiving the necessary information to process claims.
2. Deductible payments must be made directly to Align Chiropractic Wellness Center for chiropractic services rendered until deductible is met.
3. All co-payments are due at the time of service. If co-insurance payments are indicated on an Explanation of Benefits, the co-insurance is due at the time of notification.
   A **co-payment** is the amount an insurer may require to be paid per visit out- of- pocket from the subscriber (patient). A **co-insurance** is a percentage amount of the office fee to be paid by the subscriber (patient) to the provider,
4. Align Chiropractic Wellness Center, LLC will verify benefits at the patient's request. Verification of benefits is not a guarantee of payment for services.
5. The office will submit insurance claims directly to your insurance company.
6. The insurance policy is a contract between the patient (subscriber) and the insurer. If our office (the provider) has difficulty with your insurer we will require your assistance to obtain details and information. If information is not forthcoming, the privilege of accepting assignment will be terminated.
7. There is no promise of payment by an insurance company made by this office. Any services not paid by the insurance company will be transferred to the patient. As reimbursement rates and coverage of policies tend to vary from month to month, we cannot be responsible for changes in your coverage.
8. It is the goal of the office to provide you with the finest quality chiropractic care possible. However, insurance policies accommodate only symptom care and corrective care. They do not cover maintenance care. Care beyond correction or symptom care is frequently considered maintenance by insurers. Visits beyond weekly care of a treatment plan are considered maintenance by insurers. This will become patient responsibility for payment.
9. Insurers may reject claims or coverage stating a lack of medical necessity, no coverage for children or ineligible diagnosis. The patient will be responsible for these unpaid charges.

Signature_____ Date_____

Patient name _____ Date _____

Last name First name

Informed Consent for Chiropractic Treatment

I hereby request and consent to chiropractic adjustments and any other procedures, including examination, tests, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the Doctor of Chiropractic. I have had an opportunity to discuss with doctor the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither chiropractic nor medicines is an exact science, and that my care may involve the making of judgments based upon the facts known to the doctor at the time. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment. I understand that as with any health care procedure, there are certain complications which may arise during chiropractic adjustment. Those complications include but are not limited to: fractures, dislocations, stroke, muscle strain, and disc injuries. I have the opportunity to ask questions about this consent and by signing below agree to the named procedures.

Signature_____ Date_____

Authorization to Perform X-rays

Diagnostic x-rays are advisable in order that a complete analysis can be made of my present musculoskeletal condition. Upon the completion of my examination and consultation, x-rays may be necessary. I authorize the treating doctor to perform the necessary radiographs for diagnostic purposes.

Female Patients:

- ☐ I am pregnant or trying to become pregnant
- ☐ I deny any chance of pregnancy

Signature_____ Date_____

Patient name _____ Date _____

Last name First name