FAMILYFIRST CHIROPRACTIC & ACUPUNCTURE

# PATIENT PERSONAL INFORMATION

| Last Name: | First Name: | M.I. | Today's Date: |
|---|---|---|---|
| | | | |

| Preferred Name: | Date of Birth: | SSN: | Gender: ☐Male ☐Female |
|---|---|---|---|
| | | | |

| Marital Status: ☐M ☐Sgl ☐Div ☐Sep ☐Wid | Spouse's Name: | Children's Names |
|---|---|---|
| | | |

| Address 1: | Address 2: | City: | State: | Zip Code: |
|---|---|---|---|---|
| | | | | |

| Mobile Phone: | Mobile Phone Carrier: | Home Phone: | Work Phone: |
|---|---|---|---|
| | | | |

| Email: | Who referred you to us? /How did you hear about us? |
|---|---|
| | |

| Occupation: | Employer: | Employer Address: |
|---|---|---|
| | | |

| Emergency Contact: | Relationship to Patient: | Phone Number: | Phone Type: ☐Mobile ☐Work |
|---|---|---|---|
| | | | |

Purpose of Appointment / Chief Complaints:

Approximate date symptoms began:

Circumstances that worsen symptoms:

Circumstances that alleviate symptoms:

If symptom is the result of an accident, what type of accident was it? ☐Auto ☐Work Related ☐Other:

Have you seen any other doctor for this condition? ☐Yes ☐No If yes, who?

Have you been treated by a doctor for ANY health condition in the last year? ☐Yes ☐No If yes, please describe below

**INSURANCE INFORMATION:** I understand and agree that health and accident insurance policies are an agreement between and insurance carrier and I. Furthermore, I understand that *Family First Chiropractic & Acupuncture* will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. 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. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

**HIPPA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT):** I authorize Family First Chiropractic & Acupuncture to use or disclose my health information in the manner described on the following forms:

- Consent for Use of Disclosure of Health Information
- Appointment Reminders and Health Care Information Authorization
- In-office Recognition/Correspondence by Mail/Fax/Electronic Communication
- North Carolina Chiropractic Association Authorization

I am also acknowledging that I may obtain a copy of the above listed authorizations/consents and I am also acknowledging that I may obtain a copy of the Informed Consent for Chiropractic Care.

| Patient/Guardian Signature: | Date: |
|---|---|
| | |

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# ACUPUCTURE MEDICAL HISTORY

Height: _____ Weight: _____

What are your concerns and reasons for visiting today? (select all that apply)

☐ Digestive Issues ☐ Stress ☐ Insomnia ☐ Anxiety ☐ Allergies ☐ Back Pain

☐ Muscle Sprain/Pull ☐ Fatigue ☐ Joint Pain ☐ Headaches ☐ Migraines ☐ Depression

☐ Muscle Aches ☐ Fertility ☐ High Blood Pressure ☐ Menstrual Cramps/PMS

Please Describe

☐ Other

How long have you been experiencing symptoms?

Are you currently under a physician's care for this condition?

☐ YES ☐ NO

If yes, enter diagnosis? _____

Please answer all questions

| | |
|---|---|
| Are you currently taking blood thinners or on an aspirin regimen?<br>☐ YES ☐ NO | Are you currently pregnant or trying to conceive?<br>☐ YES ☐ NO |
| Do you have a seizure disorder?<br>☐ YES ☐ NO | Do you have a Hepatitis B?<br>☐ YES ☐ NO |
| Do you have HIV/AIDS?<br>☐ YES ☐ NO | Do you consume alcohol?<br>☐ YES ☐ NO |

| Do you have a known nickel allergy? | Do you use Recreational Drugs? |
|---|---|
| ☐ YES ☐ NO | ☐ YES ☐ NO<br>If Yes, please describe: _____ |

# 24-HOUR CANCELLATION POLICY

Due to an increased number of missed appointments, and limited room reservations, Family First Chiropractic & Acupuncture enforces a **24-hour cancellation policy for acupuncture appointments.** To reschedule your appointment, you must notify Family First Chiropractic & Acupuncture at 704.541.4747 as soon as possible to avoid being charged a **$50 fee** by credit card or invoice for the missed appointment. We appreciate your understanding, value your patronage, and will always do our best to accommodate your needs.

# FINANCIAL POLICY

Insurance is an agreement between you and your insurance company; we are not a party to that contract. Our relationship is with you, not your insurance company. Our office staff will do their best to inform you of your plan benefits. **However, it is ultimately the financial guarantor's responsibility to be aware of the plan's benefits. This is including, but not limited to, deductibles, copays, pre-certifications and referrals.** We will file insurance claims on your behalf. All copayments/co-insurance amounts are due at the time services are rendered. All services/fees not payable by insurance are the fiscal responsibility of the guarantor. Patients with secondary insurance policies and/or health care reimbursement plans will be required to pay the copay/deductible of the primary insurance. Payments made by secondary carriers and/or health care reimbursement plans will be credited to your account upon our receipts of such payments(s).

Patients without insurance may pay in individual per visit fee or prepay for an office determined number of visits (Care Plan) at a reduced fee. Care Plans must be paid in full no later than the second visit or completed visits may be billed at the individual non-care plan per visit fee. Care Plan refunds for unused visits are calculated by multiplying the number of visits used by the individual non-care plan per visit fee, then subtracting the amount from the prepaid Care Plan fee. **Care Plan refunds are subject to a $50 administrative fee.** Care plan visits cannot be transferred to/from any account. Refunds for unused Care Plan visits must be requested by the patient. Payment is required at the time services are rendered.

Patients with worker's compensation and personal injury billing must notify our office of your injury claim at your initial visit including insurance contract information. If you do not inform our office of your injury claim, the potential exists that we will not file claims on your behalf or aid in legal matters. Any previous financial agreements are superseded when a legal injury claim occurs.

By my signature, I indicate that I have read the abovementioned policies and understand its content. I also understand that I am responsible for all fees associated with services rendered and I agree to its provisions and the party financially responsible.

Patient Name: _____

Signature: _____ Date: ____/_____/_____

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