Potomac Family & Sports Chiropractic Center

( ) New Patient ( )Name Change ( )Address Change

Today's Date_____

Patient Name: Last_____First_____MI____ Male( ) Female( )

DOB____/__/____ Martial Status ( ) Married ( ) Single ( )Other Spouse_____

Address_____City_____State_____Zip_____

Home phone_____Work_____Ext_____Cell_____

Email_____ Social Security #_____ (required)

Emergency Contact:_____ Relationship_____ Phone_____

Who is your Primary Care Physician?_____

Who may we thank for referring you ?_____

Complete the following if patient is a minor

Responsible Party Name_____Relationship_____

Responsible Party Home #_____Work or Cell #_____

Insurance Information: Please allow us to photocopy your Insurance Card(s) and Photo Id

Policy Holder Name_____DOB_____SS#_____

ID Number_____Group Number_____

Patient relationship to Policy Holder/Insured Party: ( ) Spouse ( ) Child ( ) Other

***Please be aware that when Insurance requires a patient to obtain a written referral to see a specialist it is the patient's responsibility to bring this to the appointment or confirm with our office that your Primary Care Physican office has done this for you, prior to your appointment. If you are not sure if a referral is required please contact your Insurance Company.**

Secondary Insurance Company Name_____

Policy Holder Name_____DOB_____

ID Number_____ Group Number_____

If you have a secondary or supplemental Insurance we will file for you after your primary has processed the claim. However, in the event that the secondary does not pay within 60 days, patients will be billed the balance due.

***In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect this amount or any future outstanding account balances.**

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Patient Intake and Summary

Patient Name:_____Date:_____

1. What are your major symptoms?_____
2. What does this prevent you from doing or enjoying?
   _____
3. If this is a reoccurrence, when was the first time you noticed the problem:
   _____
4. How did the issue originally occur? _____
5. Has it become worse recently? ( )Yes ( ) No ( ) Same ( ) If yes, when and how?
   _____
6. How frequent is the condition? ( ) Constant ( ) Daily 50% of time ( ) Intermittent ( ) Night only.
7. How long does it last? ( )All day ( ) Few hours ( ) Minutes
8. Are there any other conditions or symptoms that may be related to your major symptoms?
   _____.
9. Describe the pain? ( ) Dull –Sharp ( )Numbness ( ) Tingling ( ) Aching ( ) Burning ( ) Stabbing Other:_____
10. Is there anything that relieves the problem?
    _____
11. What makes the problem worse? ( ) Standing ( )Sitting ( )Lying ( ) Bending ( ) Lifting ( ) Twisting Other: _____
12. List any major accidents you have had other than those that might have been mentioned above:_____
    _____
    _____.
13. **Women only:** Are you pregnant or is there a possibility you may be pregnant ( )Yes ( ) No ( )Uncertain.

Place an X on the line below to indicate the level of the problem for you and give it a number on 1-10 with 10 being the worse, where you are now, today.

/_____/

No symptom Extreme symptoms

Doctors Signature:_____ Date: _____

HIPAA Consent and Financial Policy

Patient Name:_____(please print) Date:_____

HIPAA: The practice provides this information to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. By signing below the patient understands:

*Protected health information may be disclosed or used for treatment, payment or health care options.

*The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.

*The practice may condition receipt of treatment upon the execution of this consent.

*The patient may revoke this consent in writing at any time and all future disclosures will then cease.

Release of Information:

Besides myself, I authorize this practice to discuss personal medical information with the following person(s):_____ and/or _____

Insurance and Assignments of Benefits:

I hereby authorize this practice and its providers to apply for benefits on my behalf for covered services rendered. I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier (or in the case of Medicare Part B benefits, to the Social Security Administration the Health Care Financing Administration). A copy of the authorization may be used in place of the original. This authorization may be revoked by either me or my insurance carrier at any time in writing.

I hereby authorize payment of all medical insurance benefits to be paid directly to this practice and/or its providers for services rendered. I understand and agree that I am financially responsible for charges not paid by insurance company. I understand that in certain instances my insurance may decide that medical services are not medically necessary and that payment may be denied for these services. I agree to be personally and fully responsible for payment or any denied charges. If I have Medicare, I understand that I may be asked to sign an advanced notice/waiver for certain services or procedures.

I hereby certify that the information I have provided is correct. I hereby certify that I have read, understand, and agree with the about HIPAA and Financial Policies. I further agree to pay bank charges for insufficient funds, finance charges and/or collection fees assessed to my account for any overdue balances.

Patient Signature/Responsible party:_____ Date:_____

Potomac Family & Sports Chiropractic Center

OFFICE POLICIES

Cancellations/No-Show policy

If you are unable to keep your scheduled appointment, please notify us at least 24 hours in advance so we can accommodate our other patients. You may also reschedule your appointment at that time.

No show policy: We do require a **24 hour** notice of cancellations. If you do not show up to your appointment without notifying us, the first time will be a **warning** and after that, you will be charged $50 for the time we were not able to fill when you were a no show.

Medical Record Policy

Each patient has a complete record of all medical care received at our office. Your personal medical record provides a history of treatment and diagnostic information that enables your health care team to make comprehensive medical evaluations. We consider your record to be confidential. Therefore, information will not be release without your written consent, unless required by law. Copies of your medical record will be released to you or transferred to another physician upon written consent. There will be a $25-50 copying fee for this service. This must be paid prior to records being released.

Completion of Forms (Family medical leave and disability forms)

A $25-50 charge will be assessed for the completion of forms outside of an office visit. The charge varies on the length of the form and the time taken to complete.

Referrals

Please be advised that patients are responsible for managing their own referrals and making sure they are covered at time of service. Upon verbal request, our office, as a courtesy, will only be able to provide the referral start and end date to assist in helping determine when referrals will expire. As the patient, this will allow you to request a new referral/ extension in timely manner. Patients are also responsible for communicating with their own PCP and/or insurance companies. We thank you in advance for your understanding and support.

Collection Policy

In case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect this amount or any future outstanding account balances.

Signature_____ Date_____

Documentation Waiver

Your signature bellows signifies that you clearly understand that:

- Our office will file a claim to your carrier.
- Certain types of plans will not reimburse our office unless we have proper documentation:
  - Paperwork must be returned to our office in a timely fashion
  - In the event we do not receive the proper documentation and/or our office is not paid, the cost will become the patients' responsibility

Do not sign this form unless you positively understand the consequences of your visit and the charges you may have to encounter.

Signature of Patient:_____ Date: _____

Patient/Family History

Patient Name:_____ Date: _____

Below are lists of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

Check any of the following diseases you have had:

( ) Pneumonia	( ) Mumps	( ) Influenza	**INTAKE**
( ) Rheumatic fever	( ) Small pox	( ) Pleurisy	( ) Coffee
( ) Polio	( ) Chicken pox	( ) Arthritis	( ) Tea
( ) Tuberculosis	( ) Diabetes	( ) Epilepsy	( ) Alcohol
( ) Whopping cough	( ) Cancer	( ) Mental Disorders	( ) Cigarettes
( ) Anemia	( ) Heart Disease	( ) Lumbago	( ) White sugar
( ) Measles	( ) Thyroid	( ) Eczema	

Have you been tested HIV positive? ( ) Yes ( ) No

Check any of the following you have had the past 6 months:

( ) Low back pain	( ) General stiffness	**FEMALES ONLY:**
( ) Pain Between shoulders	( ) Gas/bloating/after meals	Last menstrual cycle:_____
( ) Neck pain	( ) Heartburn	Are you pregnant: ( ) Yes ( ) No
( ) Arm pain	( ) Black/bloody stool	
( ) Joint pain/stiffness	( ) Colitis	
( ) Walking problems	**Genito-Urinary**	
( ) Difficult chewing/clicking jaw	( ) Bladder trouble	
	( ) Painful/Excessive Urination	
	( ) Discolored Urine	

Nervous System

( ) Nervous

( ) Numbness

( ) Paralysis

( ) Dizziness

( ) Forgetfulness

( ) Confusion/Depression

( ) Fainting

( ) Convulsions

( ) Cold/tingling extremities/stress

C-V-R

( ) Chest Pain

( ) Short Breath

( ) Blood pressure issue

( ) Irregular heartbeat

( ) Heart Problems

( ) Lung Problems/Congestion

( ) Varicose veins

( ) Ankle swelling

( ) Stroke

General

( ) Fatigue

( ) Allergies

( ) Loss of sleep

( ) Fever

( ) Headaches

ENT

( ) Vision issues

( ) Dental issues

( ) Earaches

( ) Hearing issues

( ) Stuffed nose

Gastro-Intestinal

( ) Poor/Excessive Appetite

( ) Excessive Thirst

( ) Frequent Nausea

( ) Vomiting

( ) Diarrhea

( ) Constipation

( ) Hemorrhoids

( ) Liver issue

( ) Gall bladder issue

( ) Weight issue

( ) Abdominal cramps

Male/ Female

( ) Menstrual Irregularity

( ) Menstrual cramps

( ) Vaginal pain/ infection

( ) Breast pain / lumps

( ) Prostate/Sexual dysfunction

( ) Other problems:

Family History:

Do any of the following members have any of the symptoms listed above?

( ) Paternal Mother ( ) Mother ( ) Spouse

( ) Paternal Father ( ) Father ( ) Child

( ) Fraternal Mother ( ) Brother

( ) Fraternal Father ( ) Sister

OFFICE USE ONLY

Analysis:_____
_____.

Diagnosis:_____
_____.

Patient accepted: ( ) Yes ( ) No ( ) Referred.

Reason for patient referred: _____.

Doctor's Signature: _____ Date: _____.

Potomac Family and Sports Chiropractic Center

20116 Ashbrook Place Suite 140

Ashburn VA 20147

Phone: 703-406-8686 Fax: 703-406-8688

Potomac Family & Sports Chiropractic Center

CONSENT TO TREAT A MINOR PATIENT WITHOUT PARENT PRESENT

In order for us to treat a minor without a parent/legal guardian present, please complete this form:

I,_____(print name here) am the parent/legal guardian of _____(print name of minor), currently a minor, whose date of birth is _____/_____/_____.

I authorize Potomac Family & Sports to provide medical care to my son/daughter, including but not limited to diagnostic exams and treatment procedures.

I understand that, should my minor child need more invasive care attempts will be made to contact me before such care is initiated.

I further understand that once my child reaches the age of majority, my consent for treatment is no longer required.

This consent will remain in effect until the patient reaches the age of eighteen unless revoked in writing to Potomac Family & Sports Chiropractic Center.

Payment is expected the day of the appointment and can be made by cash, check, or credit card when checking in, or in advance over the phone.

By signing this, I acknowledge I have read and agree to this consent and that any questions I had prior to signing this were answered.

_____ _____

Signature of Parent/Legal Guardian Date

Phone Numbers: Home_____ Cell:_____
Work:_____

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