Name_____Date_____

Release of Records

I, do hereby authorize Holland Family Chiropractic to release my medical and billing records to any of its billing companies, attorneys, adjusters, insurance companies, etc, for the purpose of getting my bills paid.

X_____

Consent to Treat

I, do hereby authorize Holland Family Chiropractic and their assistants to perform medical examination, physical therapy and/or noninvasive diagnostic testing to me today.

X_____

Records Transfer Request

I, do hereby authorize the release of my records, or copies of such, including any other reports or data pertinent to my treatment, and request that they be transferred to Holland Family Chiropractic.

X_____

Assignment of Benefits

I request that payment of authorized Medicare, or private insurance benefits be made Holland Family Chiropractic for any covered services furnished to me. I authorize any holder of medical information to release any information about me which is needed to determine these benefits. I agree to be responsible for the full amount of the charges if no payment has been made on a claim submitted to my insurance company; or if my physician or I fail to provide information necessary to submit the claim for a service.

X_____

Holland Family Chiropractic
7 Vanderveer Ave
Holland, PA 18966

Patient Information

Name_____ SS#_____

Address_____ Phone (H)_____

_____ Phone (W)_____

City_____Zip_____ Phone(Cell)_____

E-mail: _____ Birth Date: _____
(Receive announcements, discounts, & new promotions. We do not share or sell your personal information).

Occupation_____ Employer_____

Marital Status_____ Spouse's Name_____

Family Physician_____ Phone #_____

Whom can we thank for referring you to us today?_____

Insurance Information

Please give your Insurance Card to the receptionist. *If this is an Auto/Work related injury, please let the receptionist know. Additional information is required.*

Insurance _____ Patient Id Number_____
(Listed on the front of your card)

Policy Subscriber _____ Subscriber's Date of Birth _____
(Required in order for us to submit your claim. We cannot bill your insurance without this information. If you fail to provide the requested information, you will be responsible for full payment at the time of service).

Reason for your visit

Have you ever been treated by a chiropractor? Y N

Please Explain_____

Has anyone in your family been treated by a chiropractor? Y N

What is the reason for your visit? _____

How long have you had these symptoms? _____

Is this condition getting worse? _____

Has anyone else treated you for this condition? _____

List any surgeries: _____

List any medications you are currently taking: _____

Do you have any other health conditions we should be aware of? (Please Explain).

_____

_____

Please Check ALL That Apply

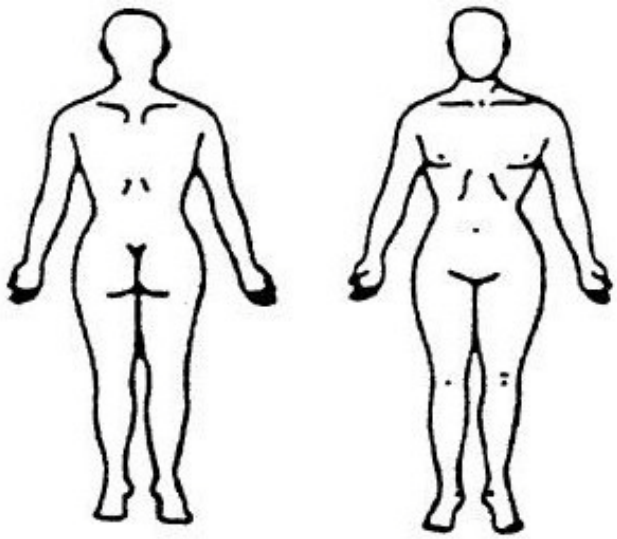
[ ] headache	[ ]shoulder arm pain L or R	[ ]leg pain L or R	[ ]fainting
[ ]neck pain	[ ]upper back pain	[ ]anxiety	[ ]pain behind eyes
[ ]neck stiffness	[ ]mid back pain	[ ]neuritis	[ ]tremors
[ ]double vision	[ ]chest pain	[ ]fatigue	[ ]nausea
[ ]numbness in arms	[ ]shortness of breath	[ ]excessive perspiration	[ ]swelling
[ ]dizziness	[ ]low back pain	[ ]tension	[ ]cold feet
[ ]pain radiating into neck	[ ]numbness in legs	[ ]restriction of motion	[ ]cold hands
[ ]irritability	[ ]sinus trouble	[ ]depression	[ ]numbness in feet
[ ]difficulty in rising to walk after sitting	[ ]difficulty bending	[ ]pain while walking	[ ]pain while standing
	[ ]difficulty in lifting	[ ]equilibrium problems	[ ]pain while sitting
[ ]difficulty in walking	[ ]difficulty in standing		

Please Circle the areas you have pain and describe the pain using the following letters:

A -Ache B- Burning N- Numbness P- Pins/Needles D- Dull S- Shooting

Please rate the severity of the pain on a scale of 1 (least pain) to 10 (severe pain) _____

Does it interfere with your **WORK SLEEP DAILY ROUTINE RECREATION**



Physical

Height _____ Weight_____ Right / Left Handed

Daily Habits

Do you exercise on a regular basis? _____ If so, what type of

exercise program? _____

Do you currently take vitamins or nutritional supplements? Please List: _____

_____

Do you smoke? _____ How many cigarettes per day? _____

Do you currently drink alcohol? _____ Daily Weekly Monthly

How much coffee (caffeine) do you drink daily? _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for services rendered at the time of visit, unless other arrangements have been made with the office manager.
- I understand that the office will verify insurance coverage and may bill my insurance carrier. In the event of no payment by my carrier, I understand I am responsible for all fees I may have incurred.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims and for the insurance payments to be made directly to the provider.
- I acknowledge that this practice is required by law to maintain the privacy of my medical information. I understand that this practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. I acknowledge that a copy of this Notice is posted and a paper copy has been provided for my review.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.
- I understand it is the policy of this practice that **24 hour notice is required for all cancellations to massage therapy appointments,** or a $20.00 missed appointment fee applies, payable by the patient only.

Signature _____Date_____

THANK YOU FOR CHOOSING OUR OFFICE FOR YOUR HEALTH CARE NEEDS