

1
one

WELCOME

ABOUT YOU

Today's Date: ____ / ____ / ____ File #: _____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ Male Female

Birthdate: ____ / ____ / ____ Age: ____ SS#: _____

Mailing Address: _____

CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____ Ext: _____

Other Phone #s: _____

E-Mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

CITY STATE ZIP

Occupation: _____

Status: Minor Single Married Divorced Separated Widowed

Spouse's Name: _____

Do you have children? Yes No How many? _____

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two

INSURANCE INFO

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____ / ____ / ____

Insured's Employer: _____

Please inform front desk of 2nd. Insurance source.

REASON FOR VISIT

The reason for this visit is a result of (*Please circle*): work, sports, auto, trauma or chronic.

(*Explain what happened*): _____

Please describe the pain & its location: _____

When did condition begin? ____ / ____ / ____

Is this condition getting worse? Yes No Constant Comes and goes

Is this condition interfering with your (*Please Circle*): work, sleep, or daily routine.

If so, please explain: _____

Have you had this or similar conditions in the past? Yes No

If so, please explain: _____

Have you been treated by a Medical Physician for this condition? Yes No

If so, where? _____

Have you ever been treated by a Chiropractor before? Yes No

If so, whom? _____ Phone#: _____

3
three

PLEASE CONTINUE ON BACK

four

IN EVENT OF EMERGENCY

Who should we contact? _____
 Relation: _____
 Home Phone #: _____ Work Phone #: _____
 Who is your Medical Doctor? _____ Phone #: _____

HEALTH HISTORY

Are you taking any of the following medications?

Nerve pills Pain killers (including aspirin) Muscle relaxers Stimulants
 Blood Thinners Tranquilizers Insulin Other(s) _____

Do you have or ever had any of the following diseases or conditions?

<input type="checkbox"/> Y N Heart Attack / Stroke	<input type="checkbox"/> Y N Heart Surg./Pacemaker	<input type="checkbox"/> Y N Heart Murmur
<input type="checkbox"/> Y N Congenital Heart Defect	<input type="checkbox"/> Y N Mitral Valve Prolapse	<input type="checkbox"/> Y N Artificial Valves
<input type="checkbox"/> Y N Alcohol / Drug Abuse	<input type="checkbox"/> Y N Venereal Disease	<input type="checkbox"/> Y N Hepatitis
<input type="checkbox"/> Y N HIV+ / Aids	<input type="checkbox"/> Y N Shingles	<input type="checkbox"/> Y N Cancer
<input type="checkbox"/> Y N Frequent Neck Pain	<input type="checkbox"/> Y N Emphysema / Glaucoma	<input type="checkbox"/> Y N Anemia
<input type="checkbox"/> Y N High/Low Blood Pressure	<input type="checkbox"/> Y N Psychiatric Problems	<input type="checkbox"/> Y N Rheumatic Fever
<input type="checkbox"/> Y N Severe/Frequent Headaches	<input type="checkbox"/> Y N Kidney Problems	<input type="checkbox"/> Y N Ulcers / Colitis
<input type="checkbox"/> Y N Fainting/Seizures/Epilepsy	<input type="checkbox"/> Y N Sinus Problems	<input type="checkbox"/> Y N Asthma
<input type="checkbox"/> Y N Diabetes / Tuberculosis	<input type="checkbox"/> Y N Difficulty Breathing	<input type="checkbox"/> Y N Chemotherapy
<input type="checkbox"/> Y N Lower Back Problems	<input type="checkbox"/> Y N Artificial Bones / Joints	<input type="checkbox"/> Y N Arthritis

Please list any other serious medical condition(s) you have or ever had: _____

Please list anything that you may be allergic to: _____

List previous surgeries/treatments with dates: _____

List any **past** serious accidents with dates: _____

Family Health History: _____

Do you: Take Supplements or Vitamins? Yes No / Exercise? Yes No

Are you on a special diet: Yes No / Since: ____/____/____

Do you smoke? No Yes / How Much? ____ How Long? ____

Are you wearing: Heel Lifts Sole lifts Inner soles Arch supports

What is the age of your mattress? ____ Is it comfortable? Yes No

For women: Are you taking Birth Control? Yes No

Are you Pregnant? No Yes/How long? ____ Nursing? Yes No

five

six

ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

CITY STATE ZIP

SSN: _____

D.L.#: _____

Work Phone#: _____

Payment method: CASH Check

Credit Card - Enter card # above (if accepted)

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- 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 to the information I have provided.

Signature _____ Date ____/____/____
 Adult Patient Parent or Guardian Spouse

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

Billing, Insurance, and Collection Policy

Village Chiropractic Center
972-317-3146
972-317-4417 (fax)

2430 F.M. 407
Ste. B
Highland Village, TX 75077

This is an agreement between Village Chiropractic Center, a Texas Professional Corporation, as creditor, and the Patient named on this form.

In this agreement the words "you," "your," and "yours" mean the Patient. The word "account" means the account that has been established in your name to which charges are made and payments credited for the services rendered to you by us. The words "we," "us," and "our" refer to Village Chiropractic Center.

Monthly Statement: It is our general policy that all charges must be paid for at the time services are rendered. If you have a balance on your account due to insurance claim procedures, we will send you an account statement. It will show separately the previous balance, any new charges to the account, late charges and/or fees, and any payments or credits applied to your account during the month.

Payment options if you have no insurance:

- A. You choose to pay by cash, check, or credit card on the day the treatment is rendered.
- B. Pre-Pay

Payment options if you have insurance:

- A. You choose to pay your deductible and any out-of-pocket portions at the time the services are rendered by cash, check, or credit card.
- B. You choose to pay all of your treatment by cash, check, or credit card. You will be responsible for filing with your insurance.
- C. Pre-Pay co-pays or get authorization to charge your credit card.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within thirty (30) days.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time without notice. Future visits would then need to be paid at the time service is rendered.

Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of you eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it and failure to

obtain the referral and/or preauthorization will not relieve you of your obligation to make full payment to us for the services rendered.

Late Charge: A one time late charge will be imposed if payment is not received within thirty (30) days of the statement. The “overdue balance” of your account is calculated by taking the balance owed thirty (30) days ago, then subtracting any payments or credits applied to your account during that time. The minimum late charge is \$10.

Re-billing Fee: A re-billing fee of \$5 will be imposed on each account that is over thirty (30) days past due. We determine your account past-due by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Returned Checks: There is a fee (currently \$30) for any checks returned by the bank for any reason.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If your account is referred to a collection agency or attorney, you agree to pay all of the collection costs which are incurred, including all reasonable attorney’s fees and expenses which we incur plus all court costs. In case a lawsuit for collection of your account is filed, you agree the exclusive venue shall be in Denton County, Texas and you agree that all services were rendered in Denton County, Texas and all invoices are payable in Denton County, Texas.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment and the type of treatment received at our office may become a matter of public record or disclosed to third parties.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible to us for those subsequent charges.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee (currently \$25) if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history and hereby indemnify and hold us harmless for any claims or damages resulting from our providing records pursuant to your request. If you request records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. Should your claim be denied you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. Payment of the bill remains the patient's responsibility.

Liability: If you are being treated for a 3rd party liability claim and do not have an attorney, we will require that you allow us to bill your health insurance or file on your Personal Injury Protection. Upon settlement of your claim, YOU WILL BE RESPONSIBLE FOR ANY BALANCE OWED ON YOUR ACCOUNT REGARDLESS OF THE AMOUNT OF SETTLEMENT YOU RECEIVE FROM THE INSURANCE COMPANY. Please understand upon settlement of your claim, the 3rd party carrier will NOT PAY US DIRECTLY; however, you remain fully responsible for payment of your account. If you do not have health insurance or PIP, we must have a letter of protection on file from an attorney. Otherwise, you will be responsible for payment in full at the time services are rendered. We have the right, at our sole discretion, to refuse to accept a letter of protection for payment of your services.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until cancelled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Authorization for Credit Card Charge: By signing this agreement, you hereby authorize us to make charges to your credit card now and in the future for services provided to you by us and all related fees and expenses.

Effective Date: By signing this agreement, you agree to all of the terms and conditions contained herein and agree that no changes to this agreement will be binding unless such changes are in writing and signed by both parties. In addition, all of the undersigned agree to pay for all services rendered to the patient in accordance with this agreement.

Patient's name: _____

Responsible party
(if not the patient): _____

Signature: _____ Date: _____

Co-Signature: _____ Date: _____

INFORMED CONSENT

- ◆ We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- ◆ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges, re-billing charges and any other expenses incurred in collecting your account.
- ◆ I authorize the staff of Village Chiropractic Center to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- ◆ 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 to the information I have provided. This includes changes of address, telephone numbers, and insurance information.

Signature: _____

Date: _____

CONSENT FOR X-RAY EXAMINATION

I _____ do hereby give my permission to Village Chiropractic Center and its representatives to take X-RAYS as deemed appropriate by the examining doctor. I also hereby declare that to my knowledge, I am not pregnant.

Signature

Date

Witness

CONSENT TO TREAT A MINOR

I hereby authorize _____ and whomever he or she may designate as assistants to administer Chiropractic care as deemed necessary to my _____ (indicate relationship of child), _____.

Dated at: _____, Texas on this _____ day of _____, 20_____.

Signed: _____
(Parent or Guardian)

Witnessed: _____