NAME: _____ **BIRTH DATE:** _____ **SEX:** M / F

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

TELEPHONE: (H) _____ **CELL:** _____ **WORK:** _____

SSN:____-____-_____ **OCCUPATION:** _____ **EMPLOYER:** _____

E-MAIL*: _____ **HOW DID YOU HEAR ABOUT US?** _____

*NOTE: EMAIL ADDRESSES WILL ONLY BE USED FOR OFFICE PUPROSES AND WILL BE KEPT PRIVATE.

CIRCLE ONE:

SINGLE MARRIED DIVORCED WIDOWED

NAME IN CASE OF EMERGENCY: _____ **PHONE NUMBER:** _____ **RELATIONSHIP:** _____

PRIMARY PHYSICIAN:_____**ADDRESS:**_____**CITY:**_____**PHONE #:**_____

OTHER PHYSICIANS :_____**ADDRESS:**_____**CITY:**_____**PHONE #:**_____

_____**ADDRESS:**_____**CITY:**_____**PHONE #:**_____

_____**ADDRESS:**_____**CITY:**_____**PHONE #:**_____

WHAT IS CURRENTLY YOUR MAIN HEALTH CONCERN? (PLEASE NAME AT LEAST ONE)

_____

_____

DATE PROBLEM/PAIN BEGAN?

_____

IF YOU HAVE PAIN, PLEASE RATE YOUR PAIN ON THE SCALE BELOW:

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0 1 2 3 4 5 6 7 8 9 10

Past Medical History: (Please circle "Yes" or "No")

Yes/No History of recent infection
Yes/No Diabetes
Yes/No Birth control pills
Yes/No Stroke
Yes/No Numbness in groin/buttocks
Yes/No Aortic aneurysm
Yes/No Osteoporosis
Yes/No Frequent urination
Yes/No Abnormal weight gain/loss
Yes/No Visual disturbances
Yes/No Arthritis
Yes/No Surgeries/Medications*: (see below)
Yes/No Family history of cancer
Yes/No Family history of diabetes

Yes/No Recent fever
Yes/No Corticosteriod use
Yes/No High blood pressure
Yes/No Dizziness/fainting
Yes/No Urinary retention
Yes/No Cancer/tumor
Yes/No Recent trauma
Yes/No Pregnancy, # births_____
Yes/No Epilepsy/seizures
Yes/No History of back/neck pain
Yes/No History of alcohol/tobacco use
Yes/No Family history of high blood pressure
Yes/No Family history of cardiovascular problems

If 'Yes' to Surgeries/Medications

Surgeries:

_____

_____

Your height: _____ Your Weight: _____

Medications:

_____

_____

_____

**I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT. IF MY INSURANCE INFORMATION IS NOT ACCURATE, OR IF IT DOES NOT COVER CHIROPRACTIC CARE, I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT. I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS (SIGNATURE ON FILE). I HAVE READ AND UNDERSTAND THE PATIENT PRIVACY NOTICE.

Patient Signature: _____ Date: _____

FINANCIAL AGREEMENT and INFORMED CONSENT

We would like to take a moment to welcome you to our office and assure you that you will receive the very best of care available for your condition. In order to familiarize you with the financial policy of this office we would like to explain how your medical bills will be handled.

Explanation of Insurance Coverage
Many insurance policies do cover chiropractic care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for chiropractic care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner as a courtesy to you.

Payment Arrangements
We require that you pay your portion at each visit. If we are unable to verify your insurance, we will ask that you pay an estimated portion until we can accurately verify your coverage. This may be up to $50. If you overpay, we will refund your money as soon as the insurance is called. If you underpay, you will be notified on your next visit. If we bill you via standard mail, past due balances may have an interest charge of 18% applied per month, starting after 90 days.

Assignment of Benefits
I hereby certify that I am eligible for chiropractic benefits offered by the insurance company. I understand that the above is not true, or if I am not eligible under the terms of my employer's Medical and Hospital Subscriber Agreement or Insurance policy, I am liable for all charges for services rendered. Also, if the above is not true, I agree to pay in full for all services received within thirty (30) days of receiving a bill from Dr. Story or health plan.

Consent to Treatment of a Minor
I (We) being the parent or guardian of _____, a minor, the age of _____ do hereby consent, authorize and request Adam Story, D.C. to administer such treatment deemed advisable, necessary or requested to the above minor. I (We) agree to hold him free and harmless from any claims, suits for damages or complications, which may result from such treatment.

Signed_____ Date_____
(Parent or Guardian)

Release of Information
If your insurance company requires medical reports or records to document your treatment or progress, your signature below authorizes this office to release the medical information necessary to process your claim.

Voluntary Termination of Care
If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

Informed Consent
All procedures in health care carry material risks and it is unavoidable to avoid all risks. The material risks inherent in chiropractic are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, burns, strokes from certain types of cervical manipulations, stiffness/soreness following treatment. We make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us. The probability of risk with chiropractic is very

small in comparison to more aggressive medical procedures. You must allow us to properly screen you for risk factors which may include x-rays for underlying weakness of bone that may lead to fracture. You must allow us to take your history including medications and take your vitals/blood pressure to assess for stroke risk. Some complications may occur despite pre-screening procedures. You are free to consult any and all doctors concerning your condition and this may include: OTC medications, prescription medications, hospitalizations and surgery. If you choose these treatments, you must sign an informed consent for those procedures with the doctor that performs them. This informed consent does not cover you for other doctors' procedures and surgeries. The risks and dangers of remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Late Fees

If you do not call us then we are left with a significant time block that was put aside for you. There is a $25 missed appointment fee for visits that are missed without calling us in advance. For bounced checks we charge a $15.00 Non-Sufficient Funds fee and for all payments not paid within 30 days of receipt there is 26% A.P.R added to your initial bill. If the late payment is still not satisfied after 60 days the interest will continue.

We hope this answers any questions you might have concerning the financial policy of this office. Once again we welcome your to our office, and will be glad to answer any further questions that you might have.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read and agree to the above. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ _____

Signature **Date**

_____

Print name