BACK TO BALANCE CHIROPRACTIC

Application For Care

Welcome to our Office! This information will help us serve you better.
Thank you for trusting us with your health.

Name:	Date:
Address:	Home Phone:
City/State/Zip:	Work Phone:
Social Security #:	Cell Phone:
Birth Date:	Age:
Driver's License:	Marital Status: M W D S DP
Your Employer:	Occupation:
Spouse's Name:	Occupation:
Children's Names and Ages:	Email:
In case of Emergency who may we contact: Name:	Phone:

Who may we thank for referring you?

Favorite Hobbies/Sports/Interests:

Purpose of this visit: (Please describe your condition, concerns, and all health related issues).

Major Fall or Accident Dates: (What has been your most major life trauma, current and past).

What do you believe is wrong?

Date present condition began? _____ How?

Have you had previous Chiropractic Care? _____ Who:

Have you had these complaints before? _____ If so when?

Is this the result of an Auto or Work Injury? _____ If so describe:

Previous Surgeries/Hospitalizations:

Current Medications:

Who is your Primary Medical Physician?

Allergies?_____Yes or _____No
If so please describe:_____
_____

Patient name:_____ File #:_____ Date_____

Dr. Amber Bush
197 W. Cherry Ave ● Porterville, CA 93257 ● Ph: 559.783.2225 Fax: 559.788.2225

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Is there any chance you are pregnant? ___ Yes ___No
(This is to certify that to the best of my knowledge I am not pregnant and this clinic has my permission to perform an x-ray. I have been advised that x-ray is hazardous to an unborn child.)

Have you ever had cancer? _____ Please describe diagnosis and treatment:

Have you ever had a serious illness? _____ Please describe diagnosis and treatment.

Do you drink alcohol? _____ How often? _____ How much? _____

Do you Smoke? _____ How often? _____ How much? _____

Do you use any recreational drugs? _____ What? _____ For how long? _____

Have there been any significant stresses in your life lately? (e.g. deaths, divorce, family, work) _____

Have you noticed a change in your ability to handle stress? _____

Do you participate in regular exercise? _____

Are there any conditions that run in your family? _____

_____

The above information is true and accurate to the best of my knowledge.

Signature: _____ Date: _____

Payment is expected at the time of visit!

I understand that payment is required at the time of service. I understand and agree that health accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the chiropractic office may prepare billing forms to assist me in making collections from my insurance company. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. 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 terminate or suspend my care and treatment, any fees for professional services rendered to me will be due and immediately due and payable. I further agree to pay all collections agency fees and other related costs incurred in collection of my account.

At the time treatment is rendered your co-payment might only be an estimated amount. After a diagnosed claim is completed by your insurance company your co-payment amount might change due to your insurance coverage.

I authorize the release of medical records to the physician to whom I may be referred. I authorize the release of any medical information necessary to process insurance claims. On a separate sheet I acknowledge that I have been informed of my rights under HIPPA.

Are you insured? Y N Company: _____
(Provide us with a copy of your insurance card).

Patient Signature: _____ Date: _____
I give authorization to check a minor patient (Please Print) _____

Parent or Guardian Signature: _____ Date: _____

Patient name:_____ File #:_____ Date_____

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INFORMED CONSENT FOR CHIROPRACTIC TREATMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

TO BE COMPLETED BY PATIENT

Patient's Name _____ Signature of Patient_____

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Name of Representative _____Signature of Representative_____

Relationship or Authority of Patient's Representative _____

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of Back To Balance Chiropractic's current privacy practices. I further acknowledge that a current copy will be given to me upon request, should any changes be made to the privacy practices.

Patient's Name _____ Signature of Patient_____

If not signed by patient, please indicate relationship:_____

Parent/ Guardian of minor or disabled patient signature:_____

Witness to Patient's Signature _____

Patient name:_____ File #:_____ Date_____

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