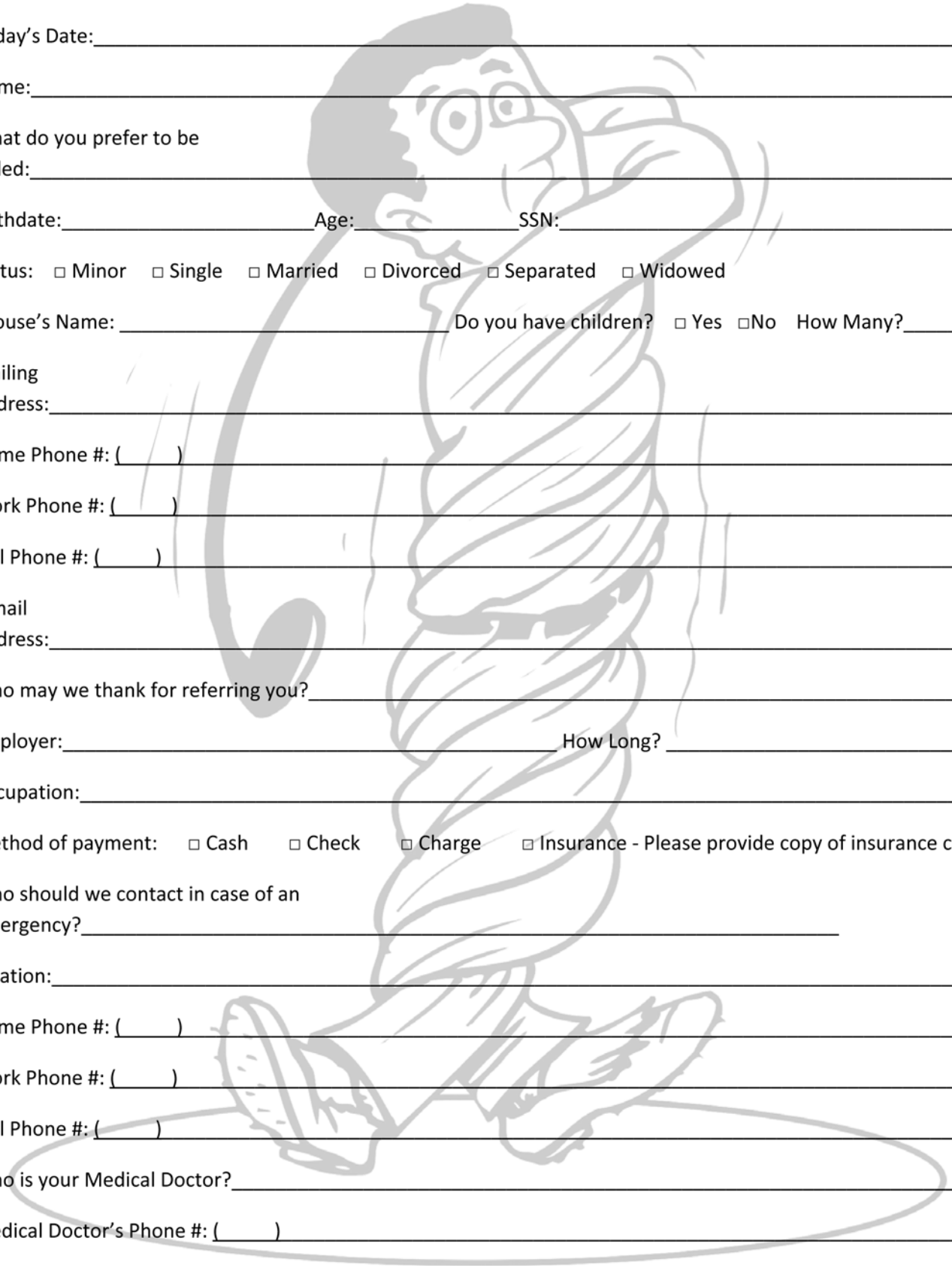
OFF-ISLAND CHIROPRACTIC

DR. RICK WOOSTER



Today's Date:_____

Name:_____

What do you prefer to be called:_____

Birthdate:_____Age:_____SSN:_____

Status: □ Minor □ Single □ Married □ Divorced □ Separated □ Widowed

Spouse's Name: _____ Do you have children? □ Yes □No How Many?_____

Mailing Address:_____

Home Phone #: (_____)_____

Work Phone #: (_____)_____

Cell Phone #: (_____)_____

E-mail Address:_____

Who may we thank for referring you?_____

Employer:_____ How Long? _____

Occupation:_____

Method of payment: □ Cash □ Check □ Charge □ Insurance - Please provide copy of insurance card.

Who should we contact in case of an emergency?_____

Relation:_____

Home Phone #: (_____)_____

Work Phone #: (_____)_____

Cell Phone #: (_____)_____

Who is your Medical Doctor?_____

Medical Doctor's Phone #: (_____)_____

Reason for today's visit: □ Emergency □ New Injury □ Old Injury □ Chronic Pain □ Wellness

What is your chief complaint?_____

When did your condition start? _____

How did your injury occur? _____

Have you had this in the past? Explain. _____

Have you seen other doctors for this condition? _____Drs. Names:_____

Describe your pain: (Sharp, dull, aching, throbbing, etc…)_____

In what position do you sleep? _____

Is your sleep disturbed by pain? _____

Have you ever been treated by a chiropractor? _____ Drs. Name: _____

Please list your medications: _____

Have you had any accidents or falls? Explain:_____

Do you take supplements or vitamins? □ Yes □ No Do you smoke? □ Yes □ No

Do you exercise? □ Yes □ No _____Hours per week

Please list any surgeries with dates and/or any other serious medical condition(s):

_____

Do you have or have you had any of the following diseases, medical conditions or procedures?

□ Alcohol/Drug Abuse	□ Cosmetic Surgery	□ Heart Surgery/Pacemaker
□ Artificial Bones/Joints	□ Difficulty Breathing	□ High/Low Blood Pressure
□ Artificial Valves	□ Emphysema/Asthma	□ HIV+/AIDS/ARC
□ Arthritis	□ Fainting/Seizures	□ Kidney Problems
□ Cancer	□ Heart Attack/Stroke	□ Severe/Frequent Headaches

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between doctor 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, interest charges 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 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:_____

Consent to Chiropractic Treatment

I authorize the performance of examination, x-ray (when needed), and chiropractic treatment to be performed by, or under the direction of, Dr. Wooster and/or such doctors/paraprofessionals/ assistants as may be selected by the doctor to perform such professional procedures, as he/she deems necessary.

I recognize that during the course of procedure unforeseen conditions may necessitate additional or different procedures/services than those set forth above and I further authorize and request Dr. Wooster to perform such procedures as are in his/her professional judgment necessary and desirable.

The nature, purpose and possible consequences of the procedures, possible alternative methods of treatment, the risk involved and the possibility of complications have been fully explained to me by my attending doctor of chiropractic.

No guarantees or assurances have been made or given by anyone as to the specific results that may be obtained and none are promised.

I, the undersigned, have read and understand the contents of this authorization.

_____ _____

Patient or authorized person signature Witness

_____ _____

Relationship (if other than patient) Date

I, _____, understand that as part of my health care, Off-Island Chiropractic originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment,
A means of communication among the many health professionals who contribute to my care,
A source of information for applying my diagnosis and surgical information to my bill
A means by which a third-party payer can verify that services billed were actually provided,
A tool for routine healthcare operations such as assessing quality and reviewing the competence Of healthcare professionals

I understand I have the following rights and privileges:

The right to object to the use of my health information for directory purposes, and
The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Off-Island Chiropractic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon . I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand the Off-Island Chiropractic reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Off-Island Chiropractic change their notice, they will send a copy of any revised notice to the address I have provided.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for this permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

_____ _____

Patient's signature Date

INSURANCE ASSIGNMENT AND "SIGNATURE ON FILE"

IT IS OUR DESIRE TO HELP FINANCIALLY, OUR PATIENTS WHENEVER POSSIBLE. THE FOLLOWING INSURANCE ASSIGNMENT PROGRAM ALLOWS YOU, OUR PATIENT, TO RECEIVE THE PROPER CARE YOU NEED WITHOUT UNDUE FINANCIAL STRAIN.

1. **Waiting for insurance payments is a courtesy provided by this office. After the initial deductible is met by the patients, we will bill your insurance company and accept assignment. (wait for payment for any treatment needed beyond the deductible.)**

2. **You will then be required to bring in or be billed for whatever small percentage the insurance does not cover. We will keep your credit card number on file. MASTERCARD, VISA OR DISCOVER. By signing this authorization, entitles our office to process any overdue balances through to your credit card. We will in turn mail to you your receipt, proof of payment.**

3. **If you receive payment from your Insurance carrier, you are to bring the check into this office so we may deduct it from your balance. We receive notice from the Insurance carrier that payment has been made to the patient, so please cooperate with us in bringing in our money.**

4. **If you discontinue your care for any reason, you will be responsible for any unpaid balance.**

5. **Although most Insurance companies cover Chiropractic Care, it will be the patient's ultimate responsibility to cover the balance in the event the Insurance company disputes or rejects the claim.**

6. **The signature below will also act as "Signature on File", which will enable us to process your claim without your personal signature each time due to the fact that we will have your signature on file.**

7. **The undersigned hereby specifically authorizes Off-Island Chiropractic to receive any Insurance company checks in payment of the aforesaid services and to endorse, deposit and negotiate said checks in payment of the aforesaid services and to endorse, deposit and negotiate said checks in payment for undersigned's obligation to Off-Island Chiropractic.**

8. **This Authorization shall remain valid unless and until revoked in writing by undersigned.**

DATE _____

SIGNATURE_____