



BACKINLINE
CHIROPRACTIC CENTER

PATIENT INFORMATION

First Name _____ Last Name _____

Gender ___ M ___ F (Are you pregnant?) ___ Date of Birth ___/___/___ Age _____

Home Address _____

City _____ State _____ Zip Code _____

Phone (Cell) _____ (Home): _____

Email _____ S.S # (last 4-digits) _____

Would you like to receive text alerts about future appointments? ___ Yes ___ No

If yes, who is your cellphone provider? _____

I authorize being contacted for practice reminders by ___ mail ___ email ___ voicemail

Employer _____

Address _____

City _____ State _____ Zip Code _____

Emergency Contact _____ Phone _____

Whom may we thank for referring you? _____

FINANCIAL RESPONSIBILITY

___ Self-Pay ___ Insurance

Insurance Company _____ I.D. # _____

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Back in Line Chiropractic Center Inc., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize Back in Line Chiropractic Center Inc. To release all information necessary to ensure payment of benefits. I authorize the use of this signature on all insurance submissions. Also, deductibles any other applicable fees are to be paid at time of service.

Responsible Party Signature (Relationship)

Date

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Financial Responsibility

I have requested professional services from Back In Line Chiropractic Center ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my, and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my insurance benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Patient

Date



PATIENT HISTORY

1. What is your major symptom/problem? _____

2. When did the symptom appear? _____
3. Have you noticed any visceral or neurological problems since the condition occurred?
(for example: high blood pressure, loss of balance, numbness, etc.)

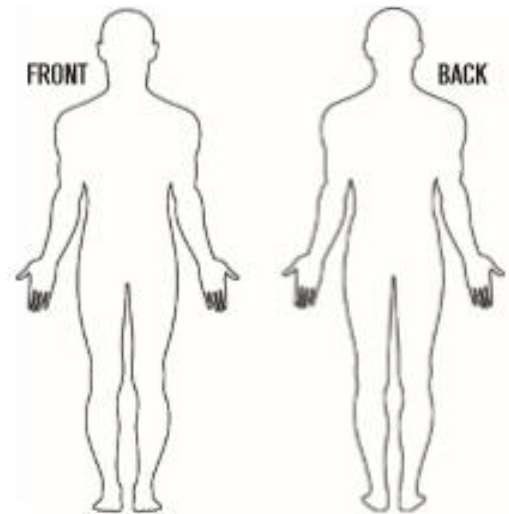
4.	Symptom/Complaint Areas (check all that apply)	Type of pain	Pain Rating 1-min 10- max	Frequency % (0-100%)
	Headaches			
	Neck Pain			
	Shoulder(s) Pain			
	Arm(s) Pain			
	Elbow(S) Pain			
	Upper Back Pain			
	Mid Back Pain			
	Lower Back Pain			
	Hip(s) Pain			
	Sciatica Pain			
	Knee(s) Pain			
	Ankle(s) Pain			
	Feet Pain			
	Other			

Type of Pain: A. Sharp B. Dull C. Throbbing

D. Numbness E. Aching F. Stiff G. Burning

H. Radiating I. Burning J. Tingling

5. In the figure below, circle the specific area(s) where you are experiencing pain, discomfort or limited range of motion.



Activities or movements that are
perform: __work __Sleep __Drive
__Sitting __Standing __Walking
__Bending __ Other _____



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MEDICAL HISTORY

1. List any and all surgery (s) and dates _____

2. Recent falls or accidents _____

3. Broken bones, dislocation or fractures _____

4. Current medications (prescription or over the counter) _____

5. Current Vitamin/Minerals or Herbal Supplements _____

6. List any allergies _____

7. Last time you saw a chiropractor _____ Dr. _____

8. Please indicate any conditions you or a family member have had in the past with (X) for yourself or (F) for family member.

__ AIDS/HIV __ Anemia __ Arthritis __ Cancer __ Diabetes __ Epilepsy __ Hypertension

__ Multiple Sclerosis __ Parkinson's Disease __ Polio __ Rheumatic Fever __ Tuberculosis

__ Tumors __ Stroke __ Heart attack __ Seizures __ Hernia __ Osteoporosis __ Other

9. Are you currently experiencing any of the following?

Difficulty __ Speaking __ Swallowing __ Walking __ Nausea/Vomiting

__ Double Vision __ Fainting or lightheadedness __ Rapid eye movement

__ Numbness on one side of the body/face __ Unusual Headaches/Migraines

Signature _____

Date _____



INFORMED CONSENT

Doctors of Chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. You should note:

1. While rare, some patients may experience short-term aggravation symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques.
2. There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes some neurological impairment and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote.
3. There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused or may be caused by spinal adjustments or chiropractic treatment.

I acknowledge I have discussed or had the opportunity to discuss with my Chiropractor the nature and purpose of Chiropractic treatment in general and my treatment (including spinal adjustment) as well as the contents of this consent.

I consent to the Chiropractic treatments recommended to me by my Chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future Chiropractic care.

Dated this ____ day of _____ 20____ Doctor Initials _____

Patient Signature _____ Print Name _____

I hereby also request and consent to the performance of: (sign)

_____ Acupuncture (I understand the methods may include but are not limited to: acupuncture needling, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine and nutritional counseling.

_____ Massage Therapy

_____ Physical Therapy

Notice: By signing this contract you are agreeing to have any issue of medical malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial. Arbitration Agreement is included in your Notice of Privacy Practices Package.

Missed appointments:

Dr. Marciante strives to provide excellent service and quality care. Therefore, we feel that it's only fair for all appointments to be kept, please provide at least 24 hrs. notice of cancellation, to timely accommodate another patient. **The cancellation fee is \$40.**

I agree and fully understand the missed appointment policy. _____(Initial)

Notice of HIPPA Privacy forms:

I have read Back in Line Chiropractic Center's Notice of Privacy Practices prior to signing this consent. Back in Line Chiropractic Center reserves the right to revise its notice of Privacy Practices at any time.

By signing this form, I am consenting Back in Line Chiropractic Center's use and disclosures of my PHI to carry out TPO.

Signature _____ Date _____

X-Ray Examination (for females only):

I am aware that the radiation exposure may be harmful to an unborn child. To the best of my knowledge, I am not pregnant at the time. I agree to diagnostic x-ray examinations as requested by Dr. Marciante. _____(Initial)

Photographs and Films:

I further agree to the taking of photographs, films, or other materials showing the condition of my mouth or my treatment for the purpose of documentation, my education and diagnosis, as well as for insurance purposes. _____(Initial)

The undersigned certifies that he/she has read and understands each of the above paragraphs and is the patient or responsible party with the power to execute this document and accept these terms. _____(Initial)

Signature of patient or responsible party/ Date

Signature of witness/ Date

Name of patient or responsible party

Name of witness