NEW PATIENT REGISTRATION

Patient I.D. _____
(For office use only)

PATIENT INFORMATION

First & Last Name: _____ Date: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Seasonal Address: _____ City: _____ State: _____ Zip: _____

Gender: ☐ Male ☐ Female Relationship Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Birthdate: _____ Home Phone: _____ Cell: _____

Work Phone: _____ E-mail Address: _____

Employer: _____ Occupation: _____ #Years: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Spouse or Parent's Name: _____ Birthdate: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____ Relation: _____

How did you hear about us? _____

Name of local primary Physician: _____ May we contact them? _____

INSURANCE INFORMATION *(If Insured, Please provide copy of insurance card)*

PRIMARY CHIROPRACTIC INSURANCE

Policy Holder: _____ Insured's SS#: _____ Birthday: _____

Insurance Name: _____ Subscriber ID#: _____

Insurance Address: _____ Ins Phone #: _____

Group ID #: _____ Employer: _____

SECONDARY CHIROPRACTIC INSURANCE

Policy Holder: _____ Insured's SS#: _____ Birthday: _____

Insurance Name: _____ Subscriber ID#: _____

Insurance Address: _____ Ins Phone #: _____

Group ID #: _____ Employer: _____

*All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize Wright Family Chiropractic to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to Wright Family Chiropractic any payable benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding amount owed to Wright Family Chiropractic.

Signature: _____ Date: _____

Patient, legal guardian or authorized agent of patient

HEALTH HISTORY

CHIROPRACTIC SYMPTOMS

Main Complaint: _____ How Bad? _____ How Often? _____

When did it start? _____ Getting Worse? _____ Getting Better? _____

What activity bothers it the most? _____

When is it at its best? _____ When is it at its worst? _____

Rate the pain (0 is pain free - 10 is unbearable pain): 1 2 3 4 5 6 7 8 9 10

Other Chiropractors? _____ Positive Experience? _____

Other types of physicians or therapists? _____ Positive Experience? _____

Secondary Complaint: _____

WHY CHIROPRACTIC?

People go to chiropractors for a variety of reasons and there are different levels of care.

Please check the type of care desired.

Stage 1 ____ Pain Relief: Just get rid of the pain, Doc! Relief is short-term

Stage 2 ____ Rehabilitation: Get rid of the pain, Doc, but then fix this problem so that it doesn't come back!

Stage 3 ____ Optimal Health: Get rid of the pain, fix the problem and then put me on a preventive maintenance plan which includes diet, exercise and chiropractic so that I stay as healthy as possible.

Are you currently in treatment for a medical condition? If so, what: _____

_____

Previous Surgeries and Dates? _____

_____

_____

List ALL Medications you are currently taking or provide a copy: _____

_____

_____

_____

What kind of exercise do you do? _____

What supplements do you take? _____

WOMEN ONLY:

How many children? _____ Pregnant? _____ Date of last Menstrual Cycle: _____

Nursing? _____ Taking Birth Control Pills? _____

CONDITIONS:

Do you have, or have you had any of the following: *(Check all that apply)*

- ☐ AIDS
- ☐ Allergy: Amoxicillin
- ☐ Allergy: Anesthetic/EPI
- ☐ Allergy: Codeine
- ☐ Allergy: Fluoride
- ☐ Allergy: Latex
- ☐ Allergy: Penicillin
- ☐ Allergy: Sulfa
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joint: type
- ☐ Asthma
- ☐ Bell's Palsy
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting/Dizziness
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Problems
- ☐ Heart: Pacemaker
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Radiation Treatment
- ☐ Raynaud's Disease
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Stents
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Substance Abuse History
- ☐ Thyroid Disorders
- ☐ TMJ
- ☐ Tobacco Use
- ☐ Tonsillitis
- ☐ Trigeminal Neuralgia
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ STD

Do you smoke? If so, how much do you smoke per day? _____

Do you drink alcohol? If so, how many drinks per week? _____

Is there anything else we need to know about your medical history? _____

_____

HEALTH QUESTIONNAIRE ACKNOWLEDGMENT AND CONSENT TO PROCEED

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change in medical condition or medications can affect chiropractic treatment, I understand the importance of and agree to notify the chiropractor of any changes at any subsequent appointment.

I authorize Wright Family Chiropractic and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my chiropractic health or the chiropractic health of any minor or other individual for which I have responsibility, including arrangement, including those related to restorative, palliative, therapeutic or acupuncture treatment.

I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child which may be associated with general preventative and operative treatment procedures in hopes of obtaining I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, necessary and have been given the opportunity to ask questions. Whether you are paying cash or using insurance, you are always ultimately responsible for your bill.

We expect payment at the time of service. By signing below, you agree to our financial policy as stated above.

Signature: _____ Date: _____

Patient, legal guardian or authorized agent of patient

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

This form will be retained in your health record.

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you can access your information.

By Signing below, I acknowledge receipt of the notice of privacy practices.

Signature: _____ Date: _____

Patient, legal guardian or authorized agent of patient

Print name if signed on behalf of patient: _____

Relationship: _____

(parent, legal guardian, personal representative, etc.)

FINANCIAL AGREEMENT

Our Financial Policy and how it Works for You:

OUR RESPONSIBILITIES

- We will verify your insurance benefits.
- We will bill your insurance for you as a courtesy.
- We will correct any errors we have made when there is a billing dispute.
- We will provide guidance in getting your bills paid.

YOUR RESPONSIBILITIES

- Please know and understand your insurance coverage.
- Please pay your deductible, coinsurance or copayment at the time of your treatment.
- Please read and keep your Explanations of Benefits statements from your insurance,
- Please follow up promptly with claims that are not paid by your insurance company, or you will be billed directly for them.
- Please make any cancellations with at least 24 hours notice or you will be billed for an office visit.

In an effort to keep costs down which are unrelated to the delivery of quality chiropractic care, payment is due at the time of service. We accept cash and personal checks, as well as Visa, Master Card, American Express, and CareCredit.

I understand that payment is due at the time of service. Should payment not be received, interest will accrue at 1.5 % per month to all unpaid balances and I will be responsible for all attorney's fees, court costs, filing fees—including charges or commissions that may be assessed to us by any collection agency retained to pursue collection of balance owing, which may be as much as 40% or the principal balance owing allowed by Utah Code Annotated sec. 12/1/11. The term of these paragraphs shall apply to all amounts incurred by me or by any individual for whom I have legal responsibility whether such amounts are incurred today or after today.

_____ [Initial]

INSURANCE CLAIMS

I understand that it is my responsibility to provide correct and updated insurance information and that this office will bill my insurance as a courtesy to me. I also understand that limitations and exclusions may exist in my chiropractic plan that have not been disclosed to Wright Family Chiropractic by my chiropractic carrier [waiting periods, deductibles, benefit restrictions, ect]. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein.

_____ [Initial]

OUTSTANDING BALANCE & CREDIT CARD ON FILE POLICY

RETURNED CHECK POLICY

We require that all patients have a credit or debit card on file. In the event of a check being returned for insufficient funds, we will charge the card on file for the returned check amount and a $25 returned check fee.

_____ [Initial]

OUTSTANDING BALANCE POLICY

Any patient carrying an outstanding balance will be responsible for paying in full before seeing or being treated by a provider. Balances that reach 90-days past due will be referred to a collection agency. The collection agency will have the authority to collect the full outstanding balance due to us plus a 25% collection fee. Our providers cannot see patients in collections until they have paid in full balance due including the collection fee.

_____ [Initial]

CREDIT CARD ON FILE POLICY

You will be asked to place a credit card on file at the time of your appointment. The information will be held securely until your insurance has paid their portion and notified us of the remaining amount. At that time, the remaining balance owed by you will be charged to your card on file and a copy of the charge will be mailed to you. This policy will in no way compromise your ability to dispute a charge or question your insurance company's determination of payment.

_____ [Initial]

We are under HIPPA policies, which means we are under strict rules and guidelines for protecting patients privacy and your credit card is considered protected health information.

By signing this statement, I acknowledge, understand and agree to abide by the terms of the returned check, outstanding balance & credit card on file policies.

Signature: _____ Date: _____

Patient, legal guardian or authorized agent of patient

APPOINTMENT CANCELLATION POLICY

Wright Family Chiropractic requires at least 24-hours notice if you need to cancel or reschedule an appointment. If you miss an appointment or cancel without 24 hours notice, a $50 cancellation fee will be charged to your card on file.

PATIENT ACKNOWLEDGEMENT:

I understand that I need to give at least 24 hours notice to cancel an appointment. If you no call/no show, you will be charged for the full amount of your appointment. If you have pre-paid visits, it will be marked as a used visit. If you are 10 minutes late or more for your appointment, your treatment may have to be rescheduled as we do have other patients scheduled after your allotted time.

Signature: _____ Date: _____

Patient, legal guardian or authorized agent of patient

CREDIT CARD AUTHORIZATION FORM

This authorization will remain in effect until canceled. You may cancel this authorization at any time by contacting us.

Please complete all fields.

Card Type: ☐ Visa ☐ Mastercard ☐ AMEX ☐ Other _____

Cardholder Name (as shown on card):_____

Card Number: _____CVV#_____

Expiration Date (MM/YY): _____/_____ ZIP Code (from credit card billing address): _____

I, (NAME) _____ authorize Wright Family Chiropractic to charge my credit card for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Cardholder Signature: _____ Date: _____