Acct # _____ Provider _____ CA _____ Today's Date ____/____/____

CHARLOTTE CHIROPRACTIC CENTER PLLC

Patient Name: _____ **Date of Birth:** ____/____/_____

Address: _____ **Apt#:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Email Address _____

What do you prefer to be called? _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Smoking Status: ☐ Never ☐ Former Smoker ☐ Current Every Day Smoker ☐ Current Some Day Smoker

If you answer "yes" to any of the following questions, please explain as clearly as possible:

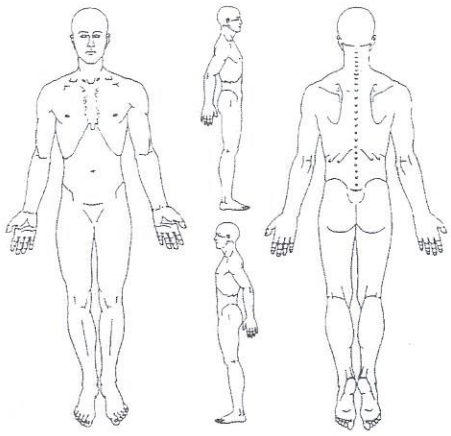
☐ Yes ☐ No Do you frequently suffer from stress?
☐ Yes ☐ No Do you have diabetes?
☐ Yes ☐ No Do you experience frequent headaches?
☐ Yes ☐ No Are you pregnant? (Due Date _____)
☐ Yes ☐ No Do you suffer from arthritis?
☐ Yes ☐ No Are you wearing contact lenses?
☐ Yes ☐ No Are you wearing dentures?
☐ Yes ☐ No Do you have high blood pressure?
☐ Yes ☐ No Are you taking blood pressure medication?
☐ Yes ☐ No Do you suffer from epilepsy or seizures?
☐ Yes ☐ No Do you suffer from joint swelling?
☐ Yes ☐ No Do you have varicose veins?
☐ Yes ☐ No Do you have any contagious diseases?
☐ Yes ☐ No Do you have osteoporosis?
☐ Yes ☐ No Do you have any allergies? Explain below.
☐ Yes ☐ No Do you bruise easily?
☐ Yes ☐ No Any broken bones in the past two years?
☐ Yes ☐ No Any injuries in the past two years?
☐ Yes ☐ No Do you have cardiac or circulatory problems?
☐ Yes ☐ No Have you ever had surgery? Explain below.
☐ Yes ☐ No Other medical condition, or are you taking any medications? Explain below.
☐ Yes ☐ No Do you or have you ever had cancer?

Comments/Explanation: _____

_____

_____

_____



If answering "yes" to any of the following questions, please indicate on the body map to the left the specific areas affected.

☐ Yes ☐ No Do you have tension or soreness in a specific area?

☐ Yes ☐ No Do you suffer from back pain?

☐ Yes ☐ No Do you have numbness or stabbing pains?

☐ Yes ☐ No Are you sensitive to the touch or pressure in any area?

Comments/Explanation: _____

_____

Acct # _____ Provider _____ CA _____ Today's Date ____/____/____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Retired ☐ Student (Full/Part Time)

Employer's Name: _____ **Occupation:** _____

Emergency Contact: _____ **Relationship:** _____
Phone Number: _____

Family Physician (MD): _____ **Practice Name:** _____ **Phone:** _____

Who referred you to our office? We'd like to thank them! _____

Chief Complaint: _____ **When did it begin:** _____

Is this visit the result of an injury? ☐ No ☐ Yes If yes, please check one below:

☐ Auto Accident (___/___/___) ☐ Work Injury (___/___/___) ☐ Other Injury (___/___/___)

Please Explain: _____

★★★

Massage Cancellation & Financial Responsibility

Please be advised of the policies for this office. Your signature below signifies acceptance of these policies.

Cancellation

A 24-hour notice is required for cancellation of a massage appointment, or you will be charged 50% of the full-price massage (ie, for a 1-hour massage, $35 will be charged). Payment is due before your next appointment.

Tardiness

Appointment times are as scheduled and cannot extend beyond the stated time to accommodate late arrivals. Please be on time for your appointment.

Sickness

Massage/bodywork is not appropriate care for infectious or contagious illness. Please cancel your appointment as soon as you are aware of an infectious or contagious condition. If it is within the 24-hour notice period, the cancellation fee may be waived.

If this office if providing billing services, please be advised of our billing policies.

Cancellation

We do not bill insurance companies for missed appointments or late cancellations. You are responsible for paying the missed appointment/late cancellation fees.

Financial Responsibility

Once your insurance is verified, we will bill and accept payment from your insurance company for covered services. In the event that the insurance company denies payment or makes partial payment, you are responsible for the balance, deductibles, and co-pays. Your signature below confirms your financial responsibility for all services regardless of insurance reimbursement.

Acct # _____ Provider _____ CA _____ Today's Date ____/____/____

Assignment of Benefits

Your signature below authorizes and directs payment of medical benefits to the massage/bodywork practitioner for services provided by this office.

Release of Medical Records

Your signature below authorizes the release of all of your medical records on file in this office, for the purpose of processing your claims, to the following: your attorney, the healthcare providers attending to this condition, and the insurance case managers. Medical records will not be edited unless otherwise stated in an exclusive release of medical records signed through your attorney.

Patient Signature _____ Date ____/____/____

Practitioner Signature _____ Date ____/____/____