VIRGINIA FAMILY
Chiropractic & Physical Medicine

AUTHORIZATION FOR CHIROPRACTIC TREATMENT

I, the undersigned, a patient in this office, hereby authorize Virginia Family Chiropractic to administer such treatments as is necessary, and to perform the following therapy and manipulation and such additional therapy or procedures as are considered therapeutically necessary on the basis of finding during the course of said treatment.

I hereby certify that I have read and dully understand the above Authorization for Chiropractic treatment, the reason why the above named treatment is considered necessary, the benefits and risks the side effects of the treatment, which were explained to me by Virginia Family Chiropractic.

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

My doctor has responded to all of my requests for information about proposed treatment. I have read, or have had read to me, the above consent. I have also had the opportunity to ask about its content. By signing below, I consent to treatment. I also certify that no guarantee of assurance has been made as to the results that may be obtained.

_____ _____

Print Name Date

_____

Signature

_____

Witness or Nearest Relative

VIRGINIA FAMILY
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Health Care Authorization Form (HIPAA)

❑ **ALEXANDRIA**
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❑ **WOODBRIDGE**
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❑ **MANASSAS**
8420 Dorsey Circle Suite 101
Manassas, VA 20110
P: (703) 367-7878
F: (703) 367-0009

THE FOLLOWING AUTHORIZES VIRGINIA FAMILY CHIROPRACTIC & PM PLLC TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATION:

I give permission to Virginia Family Chiropractic PM PLLC to use my name, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related email messages, text messages, and information about treatment alternatives or other health related information.

I give permission to Virginia Family Chiropractic PM PLLC to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a doctor or assistant in private, the doctor or assistant will provide a private room for these conversations BY APPOINTMENT ONLY.

By signing the following, you are giving Virginia Family Chiropractic PM PLLC permission to use and disclose your protected health information in accordance with the directives listed above.

_____ _____

Signature of Patient/or Guardian Date

_____

Printed Name of Patient/or Guardian

ACKNOWLEDGEMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures: I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health care information for directory purpose.
- The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations.

_____ _____

Signature of Patient/or Guardian Date

_____

Printed Name of Patient/or Guardian

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Patient Registration and History Questionnaire

Name:_____ Age:___ Date of Birth:_____ Date:_____
Last First MI
Address:_____ Social Security #:_____-_____-_____

City, State, Zip:_____ Marital Status: M S W D

Home Phone: (_____)_____ Work/Cell Phone: (____) _____

Email: _____@_____.com Employer:_____
Occupation:_____ How were you referred to this office?_____

In case of an emergency, notify _____ Relationship:_____
Phone: (_____)_____

Reason for Office Visit:	**Date condition started:**	**Have you had this before?**	**Injury related?**
1._____	_____	[ ] yes [ ] no	[ ] yes [ ] no
2. _____	_____	[ ] yes [ ] no	[ ] yes [ ] no
3 ._____	_____	[ ] yes [ ] no	[ ] yes [ ] no

Pain severity: If 10 is the worst pain imaginable, and 0 is no pain, please indicate your pain over the last 2 weeks:

Pain location:_____		Pain location:_____		Pain Location:_____	
RIGHT NOW:	____/10	RIGHT NOW:	____/10	RIGHT NOW:	____/10
At its WORST:	____/10	At its WORST:	____/10	At its WORST:	____/10
At its BEST:	____/10	At its BEST:	____/10	At its BEST:	____/10

What makes your pain BETTER? (Check all that apply):
[ ] Nothing [ ] Ice [ ] Heat [ ] Massage/Rubbing [ ] Exercise/Activity [ ] Sitting
[ ] Standing [ ] Rest [ ] Stretching [ ] "Popping" the joints [ ] Bracing/taping [ ] Laying

What makes your pain WORSE? (Check all that apply):
[ ] Coughing [ ] Sneezing [ ] Bearing Down [ ] Sexual Intercourse [ ] Running [ ] Standing
[ ] Lifting [ ] Bending [ ] Pushing [ ] Pulling [ ] Driving [ ] Sitting
[ ] Walking [ ] Laying Down [ ] Movement of the head [ ] Movement of the low back
[ ] Other_____

Pain Quality: How would you describe your pain/discomfort (check all that apply)
[ ] Dull [ ] Achy [ ] Stiff [ ] Intense [ ] Throbbing [ ] Sharp [ ] Sharp with movement
[ ] Stabbing [ ] Shooting [ ] Burning [ ] Constricting [ ] Annoying [ ] Tight [ ] Unbearable

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Numbness/Tingling (pins and needles): [ ] Yes, [ ] No: Please describe where and when you feel these symptoms:_____
Are symptoms: -Constant >75%- -Frequent 51-75%- -Occasional 26-50%- -Intermittent <25% of your waking hours
Have you seen a Chiropractor before? [ ] yes [ ] no Who?_____
When?_____ Reason for visits?_____
How did you respond?_____

Medical Doctors:
Name:_____ Date of last visit:_____ Is this your primary care provider? [ ] yes [ ] no
Name:_____ Date of last visit:_____ Is this your primary care provider? [ ] yes [ ] no
Name:_____ Date of last visit:_____ Is this your primary care provider? [ ] yes [ ] no

Surgeries/Hospitalization and dates:_____
_____

Medication: OTC/Persciption/Supplements/Vitamins:_____
_____

Please list all serious illness and serious accidents: **Month and Year:** **City, State:**
_____
_____
_____

List any allergies to medications, food or other:_____
_____

Are you pregnant? … Yes … No First day of last menstrual cycle: _____
Do you smoke? … Yes … No; How much? _____Do you drink alcohol? … Yes … No; How much?_____

Please list any recent x-rays, lab or other tests: **Month and Year:** **Facility/Doctor:**
_____
_____
_____

Do you have a history of any of the following diseases?

Tuberculosis	… Yes	Lung Disease	… Yes	Gout	… Yes	Diabetes	… Yes
Kidney Disease	… Yes	Stomach/Ulcer	… Yes	Heart Attack	… Yes	Hepatitis	… Yes
Sciatica	… Yes	Blood Pressure	… Yes	Transfusion	… Yes	Polio / MS	… Yes
Colon Disease	… Yes	Stroke	… Yes	Cancer	… Yes	Bleeding	… Yes
Paralysis	… Yes	Seizures	… Yes	Arthritis	… Yes	Asthma	… Yes
Anemia	… Yes	Thyroid Disease	… Yes	Drug Dependence	… Yes	AIDS	… Yes

Any other condition(s) not listed above that the doctor should be made aware of:
_____
_____

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Postural distortions from subluxations in your neck, upper back, middle back and low back will negatively influence and affect the nerves throughout the entire body. Do you NOW or have you EVER experienced:

CERVICAL SPINE (NECK):

[ ] Neck pain [ ] Headaches [ ] Pain into shoulders/arms/hands [ ] Immune system weakness
[ ] TMJ/pain/clicking [ ] Dizziness/fainting [ ] Weakness in grip [ ] Arthritis in the neck
[ ] Allergies/ hay fever [ ] Allergies [ ] Visual disturbances [ ] Hearing disturbances
[ ] Coldness in hands [ ] Low energy/fatigue [ ] Recurrent colds/flu [ ] Thyroid conditions
[ ] Sinusitis [ ] Depression [ ] Numbness/tingling in arms/hands [ ] Anxiety

THORACIC SPINE (UPPER BACK):

[ ] Upper back pain [ ] Shoulder pain [ ] Heart attacks/angina [ ] Pain on deep inspiration/expiration
[ ] Heart palpitations [ ] Tachycardia [ ] Shortness of breath [ ] High blood pressure
[ ] Heart murmurs [ ] Asthma/wheezing [ ] High Cholesterol [ ] Recurrent lung infections/bronchitis

THORACIC SPINE (MID BACK):

[ ] Mid back pain [ ] Pain into ribs/chest [ ] Scoliosis [ ] Kidney disease [ ] Diabetes
[ ] Ulcers/gastritis [ ] Indigestion/Heartburn [ ] Hypoglycemia [ ] Gall bladder problems [ ] Nausea
[ ] Acid reflux [ ] Tired/irritable after eating or when you haven't eaten for awhile

LUMBAR SPINE (LOW BACK):

[ ] Low back pain [ ] Pain into hips/legs/feet [ ] Weakness/injuries in hips/knees/ankles
[ ] Numbness/tingling in legs/feet [ ] Muscle cramps in legs/feet [ ] Coldness in legs/feet
[ ] Recurrent bladder/urinary tract infections [ ] Muscle cramps in legs/feet [ ] Constipation
[ ] Menstrual irregularities/ cramping [ ] Diarrhea [ ] Sexual dysfunction [ ] Scoliosis

FAMILY HEALTH HISTORY:

Have any of your biological family members ever been diagnosed with the following:
[ ] Mental Health Disease [ ] Neurological Problems [ ] Lung Disease [ ] Thyroid [ ] Arthritis
[ ] Circulatory Problems [ ] Heart Murmur [ ] Cancer [ ] High Blood Pressure [ ] Heart Disease
[ ] Stroke [ ] Diabetes [ ] Scoliosis [ ] Kidney Disease [ ] Migraine Headaches

RADIOGRAPHY CONSENT:

In order to best determine the cause and extent of my underlying spinal problems, I hereby give my consent to allow Virginia Family Chiropractic PM, PLLC to take spine and other relevant radiographs as deemed clinically necessary through chiropractic history/examination and in accordance with clinical usage indications as published in the Practicing Chiropractors Committee on Radiology Protocols for Biomechanical Assessment of Spinal Subluxation in Chiropractic Clinical Practice (2009).

_____ _____
Signature of Patient/or Guardian **Dat**

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Payment Policy

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We provide you with the same information your insurance gives our billing coordinator. If you have any additional questions regarding your benefits or coverage, please contact your insurance carrier directly.

Co-payments are to be made at **EACH** visit. If you have a **co-insurance,** you will pay a portion at the time of each visit. For example if your portion is 10%, you would pay $10 each visit; 20%, you would pay $20 and so on. You may owe an additional amount which we will collect once your claim has been processed.

Patients that have **deductibles** will be responsible for the contracted rate of your treatment per visit until the deductible has been met. This payment will be applied to your deductible once we receive an explanation of benefits from your insurance carrier. You may owe an additional amount which we will collect once all insurance payments have been applied, or have a credit depending on the claim processing.

Referrals: Insurance companies (HMO's) sometimes require their members to obtain a referral from their primary care doctor before seeing a specialist such as a chiropractor. **It is your responsibility** to obtain a referral if needed, and you must do so prior to your scheduled appointment or you will be forced to reschedule. If a referral is not received, you are financially responsible for any charges incurred for that date of service. Be aware that most referral authorizations are good for a certain number of visits and have an expiration date. If you have any questions about obtaining a referral we will be happy to assist you.

The contracted rate is an estimate we have of what your insurance allows. If you have an outstanding balance we will send you (3) statements. If we do not receive payment by the third which is the final statement, further collection action will take place immediately. Should you have any questions regarding the statement, PLEASE CALL US IMMEDIATELY in order to speak with the billing coordinator.

Returned Checks: You will be charged a $40 returned check fee if a personal check is returned for nonpayment.

A fee of $25.00 is charged if you do not cancel at least 24 hours prior to your scheduled appointment time or "**no-show**."

PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE. DATE

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE.

Patient History Review of Systems

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0 = NEVER HAD 1 = PATIENT PRESENTLY HAS 2 = PREVIOUSLY HAD

	GENERAL		MUSCULOSKELETAL		NEUROLOGICAL
	Recent weight gain		Arthritis		Lightheaded/dizzy
	Recent weight loss		Rheumatoid arthritis		Memory loss
	Fatigue		Broken bones		Headaches
	Fever		Osteoporosis		Migraines
	Allergies		Gout		Numbness
	Loss of appetite		Scoliosis		Weakness
	Chills		Spinal trauma		Stroke
	Cancer of any kind		Joint pain (anywhere)		Tingling/Numbess
	CARDIOVASCULAR		**RESPIRATORY**		**INTEGUMENTARY (SKIN)**
	Heart attack		Coughing		Bruise easily
	Swelling of ankles		Coughing up blood		Skin rashes
	High blood pressure		Chronic cough		Discoloration
	Low blood pressure		Chest pain		Psoriasis
	Shortness of breath		Asthma		Changes in moles
	Pain down left arm		Pneumonia		Sores
	Profuse sweating		Bronchitis		Scars
	High cholesterol		Tuberculosis		Itching
	EYES, EARS NOSE & THROAT		**GASTROINTESTINAL**		**GENITOURINARY**
	Blurred vision		Gall bladder problems		Painful urination
	Double vision		Liver problems		Blood in urine
	Ear pain		Pain over stomach		Frequent urination
	Hoarseness		Ulcers		Kidney infection
	Nose bleeds		Colitis		Kidney stones
	Glaucoma		Hiatal hernia		Incontinence
	Dental problems		Blood in stool		

OTHER/EXPLAINATIONS:

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE.