VERTICAL WELLNESS

Patient Information

Name: _____ Date of Birth: _____ Age:___

Cell Phone_____ Home Phone _____

Email Address _____

Street Address _____

City _____ State_____ Zip Code _____

Occupation_____Employer_____

Emergency Name _____ Relationship _____

Emergency Number _____

Who may we thank for referring you to our office? _____

Have you had chiropractic care before? ❑ Yes ❑ No

If so: Last Visit _____ Doctor/Clinic Name _____

Do you have insurance that covers chiropractic? ❑ Yes ❑ No

Primary Insurance: ❑ PPO ❑ HMO ❑ Other _____

Primary Insurance ❑ Blue Cross ❑ Blue Shield ❑ Aetna ❑ Cigna ❑ Other _____

Patient Name:_____ DOB: _____

Subscriber Name:_____ DOB: _____

Patient's Relationship to Subscriber:_____

ID Number:_____Group #: _____

VERTICAL WELLNESS

Patient Name: _____ Date: _____

Present Illness /Conditions:					
☐ AIDS	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High / Low blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate	☐ Diverticulitis	☐ Asthma
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Joint replacement	☐ Scoliosis	☐ Hernia
☐ Bone fracture	☐ Sinus trouble	☐ Mental/ Emotional Difficulty	☐ Headaches	☐ Jaw pain	☐ Neck pain
☐ Upper back pn	☐ Chest Pain	☐ Lower back pain	☐ Shoulder pn	☐ Forearm pain	☐ Wrist pn
☐ Shoulder pain	☐ Mid back pain	☐	☐ Hip pain	☐ Knee pain	☐ Ankle pn

Surgeries: Please check the surgeries that you had plus and enter the date of the surgery.

☐ Tonsils ☐ Colon ☐ Hernia ☐ Appendix ☐ Gall Bladder ☐ Stomach
☐ Heart ☐ Kidney ☐ Neck ☐ Back ☐ Other _____

Family History of illness:					
☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ STD'S	
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Ulcer
☐ Anemia	☐ Cirrhosis/hepatitis	☐ HIV/ARC	☐ Mental/ Emotional Difficulty	☐ Epilepsy	☐ Polio
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Prostate trouble	☐ Thyroid trouble	☐ Scoliosis
☐ Rheumatic fever	☐ Tuberculosis	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	☐ Diverticulitis

Cancer Type:

Social History:

Alcohol? ○ No ○ Yes Drinks per day?	Cigarettes? ☐ No ☐ Yes Packs per day?	Caffeine? ☐ No ☐ Yes Drinks per day?	Exercise? ☐ No ☐ Yes Hours per week? (circle one) Light / Moderate / Strenuous

Medication: Please list all medications you are currently taking:

1. _____ 3. _____ 5. _____ 7. _____
2. _____ 4. _____ 6. _____ 8. _____

Nutritional Supplements: Please list all nutritional supplements you are currently taking:

1. _____ 3. _____ 5. _____ 7. _____
2. _____ 4. _____ 6. _____ 8. _____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I authorize, Vertical Wellness (to include but not be limited to Dr. Mark, and hereby referred to as VW), to release any information deemed appropriate concerning my condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges occurred at this office, including to use and disclose my personal health information (which includes information about my health or condition, analysis, and the treatment provided to me) in order for the practice to make analyses about my condition(s), treat me, obtain payment for that treatment, and as necessary for the practice to conduct its specific health care operations.

I authorize and assign the direct payment to VW of any sum I now or will owe VW by my attorney, out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for VW services of otherwise obligated to make payment to me or to VW based in whole or in part upon the charges for services rendered.

I give assignment lien against any claims against a third party whose negligence may be caused by my injury, up to the bill for treatment. In the event any insurance company obligated by contractual agreement to make payment to me or to VW for the charges made for your services refuses to make such payment upon demand by VW, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name (s) of which I believed to be correctly set forth under pertinent data included) and authorize VW to prosecute said action either in my name or as you see fit and further authorize VW to comprise, settle or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance proceeds (whether it is all or part of what is due) I personally owe you.

Initial:_____

FINANCIAL ARRANGEMENT

I understand that VW has conservative fees and comfortable payment arrangements. VW wants to make sure patients can receive the needed care in an affordable manner. If I have insurance coverage, VW will provide the courtesy of billing my insurance company. The amount of your insurance coverage and out-of-pocket expense will be discussed. If I choose to enter into care at our office different payment options will be available.

Please note: A quote of coverage benefits by the insurance company is **NOT A GUARANTEE OF PAYMENT**.

IN THE EVENT THE INSURANCE COMPANY REJECTS OR DENIES MY CLAIM I WILL BE RESPONSIBLE FOR FULL PAYMENT OF ALL SERVICES RENDERED. IF VW IS BILLING MY INSURANCE AND MY INSURANCE CARRIER HAS NOT PAID A CLAIM WITHIN 90 DAYS, I WILL BE RESPONSIBLE FOR TAKING AN ACTIVE PART IN THE RECOVERY OF THE CLAIM. AFTER 120 DAYS, I WILL BE RESPONSIBLE FOR PAYMENT IN FULL FOR ANY OUTSTANDING BALANCE.

In the event of discontinuation of care, I will be billed for any outstanding balance and payments are expected within 60 days.

If my bill remains unpaid after 120 days and no satisfactory payment arrangements have been madetowards reconciling it, then the debt on your account may be assigned to a collection agency.

Initial:_____

PATIENT CONSENT

I understand that chiropractic manipulation and physio therapies are procedures that come with inherent risks, as with any healthcare procedure and provider. Certain complications which may arise during chiropractic manipulation and sports therapy procedures may include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, ligament strains and separations, skin irritation, bruising, and burns. Fractures are very rare occurrences and generally result from some underlying weakness of the bone. Some types of chiropractic manipulation of the neck have been associated with injuries to the arteries in the neck leading to, or contributing to, serious complications including stroke. The incidences of stroke are exceedingly rare and are estimated to occur one in every five million cervical manipulations.

Most commonly, some people experience some stiffness and soreness following the first few days of treatment.

Every reasonable effort will be made during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

I understand the above and will discuss the information provided and my discuss alternatives/options of my injury with the chiropractor at Vertical Wellness. I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Initial:_____

Patient Name:_____ Sign:_____ Date:_____

Parent Name(if Pt's a minor):_____ Sign:_____ Date:_____