Reinhold Chiropractic Group

Our mission is to make our local community a healthier place to live and work, enabling others through better health to have a more positive impact on the lives of the people they interact with on a daily basis.

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

**Have you had chiropractic care before?*_____ *If so, when was your last adjustment?*_____

Name:_____ Name you prefer to be called:_____

Address:_____ City/State/Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Easiest Phone # to Reach You: ❑Home ❑Work ❑Cell Email Address:_____

Social Security Number:_____ Date of Birth:_____

Employer:_____ Employer Address:_____

Marital Status: ❑Married ❑Single ❑Divorced ❑Widowed

Spouse's Name:_____ Spouse's Date of Birth:_____

Spouse's Employer:_____ Address:_____

Children's Names and Ages:_____

Emergency Contact (someone not living in the house with you):_____

Address:_____ Phone Number:_____

Do you want us to file your insurance for you? ❑Yes ❑No
IF YES, PLEASE PRESENT YOUR INSURANCE CARD AT THE FRONT DESK.
Name/Birthdate of Policy Holder if NOT you: _____

PLEASE **CIRCLE** ANY CONDITIONS YOU HAVE **NOW**.

CHECK THE BOX FOR ANY YOU HAVE HAD IN THE **PAST**.

❑Dizziness	❑Neck Pain	❑Hiatal Hernia	❑HIV-Positive Test	❑Allergies
❑Sinus Problems	❑Asthma	❑Reflux	❑Anemia	❑Sciatica
❑Migraine	❑Heart Condition	❑Irritable Bowel	❑Polio	❑Mid-Back Pain
❑Other Headaches	❑Tuberculosis	❑Ulcers	❑Osteoporosis	❑Low Back Pain
❑Earaches	❑Emphysema	❑Low Energy	❑Bone Disease	❑Herniated Disc
❑Ringing in the Ears	❑Stroke	❑Diabetes	❑Pacemaker	❑Other (specify)
❑Frequent Cold/Flu	❑Digestive Problems	❑Cancer	❑Arthritis	_____

What would you like us to help you with?_____

_____

_____

Do you consent to having an x-ray examination today? ❑ Yes ❑ No
FEMALES: Is there a possibility that you might be pregnant? ❑Yes ❑No

Signature_____ Date_____

PATIENT FINANCIAL POLICY

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. An interest charge of 1.5% per month may be applied to balances in excess of 30 days from the time of service. If collection action is necessary, I agree to pay any collection, attorney and/or court fees incurred by Reinhold Chiropractic Group in the collection of my past due balance. Our collections attorney fees are $33^{1}/_{3}$ % in addition to any outstanding balance for services rendered.

I understand that any returned checks are subject to a $25 fee. I also understand that I will incur a charge of $25 for any missed appointments without prior notice (no shows).

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that the charges incurred in this office are my responsibility. I understand that payments made by my insurance company are authorized to be paid directly to Reinhold Chiropractic Group and will be credited to my account on receipt.

If your insurance company requires medical reports to document your treatment and progress, your signature below authorizes the release of medical information necessary to process your claim and gives our office your approval to act on your behalf in communications with your insurance company.

Signature:_____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of Reinhold Chiropractic Group's **Notice of Privacy Policies**, detailing how my health information may be used and disclosed as permitted under state and federal law. I understand the contents of the notice, and I request the following restrictions concerning the use of my personal health information:

_____

_____

Signature: _____
Date: _____

If not signed by the patient, please indicate relationship to patient (ex. mother, father)

Relationship: _____
Witnessed By: _____

IF PATIENT REFUSES TO SIGN, INDICATE YOUR ATTEMPT TO OBTAIN A SIGNATURE BELOW:

__ Patient refused to sign this acknowledgement

Date: _____
Employee Signature: _____
Signature:_____ Date:_____