BOURDAGE CHIROPRACTIC

PATIENT INFORMATION

Name: _____ Birthdate: _____ Age: _____ ☐ Male ☐ Female

If Patient is a minor under age 18, Guardian Name: _____ Cell: (____) _____

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

Home: (____) _____ Cell: (____) _____ Email: _____

Status: ☐ Single ☐ Married ☐ Civil Union ☐ Divorced ☐ Widowed

# of Children: _____ Names/Ages: _____

Preferred method of contact: ☐ Home ☐ Cell ☐ Email ☐ Text (Phone Carrier) _____

Are you employed? If Yes, Name of Employer: _____

Are you a Student? If Yes, Name of School: _____

Emergency Contact Name: _____ Phone: (____) _____

Most patients are referred to us by a caring family member or friend. How or who referred you to us? _____

_____

HEALTH CONCERNS

Please list your concerns in order of importance:

1. _____ 3. _____

2. _____ 4. _____

Since concern #1 started, it is: ☐ Same ☐ Getting Better ☐ Worse

What makes it better? _____

What makes it worse? _____

Does it interfere with: *(Check all that apply)* ☐ Leisure ☐ Work ☐ Sleep ☐ Sports ☐ Other

Please explain: _____

Have you seen other doctors for this condition? *(Check all that apply)* ☐ Chiropractor ☐ MD ☐ Other

Name/Phone Number/Address: _____

_____

Please list all medications you are taking and why: _____

_____

_____

Have you had any surgeries and/or hospitalizations? ☐ Yes ☐ No

If yes, please explain: _____

Auto and Work related injuries can cause serious spinal problems. Is this visit related to an accident or injury? ☐ Yes ☐ No

If yes, please explain: _____

Please check all symptoms you have ever had, even if they do not seem related to your current problem:

☐ Headaches/Migraines	☐ Buzzing in ears	☐ Cold hands	☐ Mood swings
☐ Pins & needles in arms	☐ Ringing in ears	☐ Cold feet	☐ Loss of smell
☐ Pin & needles in legs	☐ Numbness in toes	☐ Fever	☐ Loss of taste
☐ Dizziness	☐ Depression	☐ Urinary problem	☐ Back pain
☐ Numbness in fingers	☐ Constipation	☐ Fainting	☐ Neck pain
☐ Fatigue	☐ Menstrual pain	☐ Sensitive to bright light	☐ Stiff neck
☐ Sleeping problems	☐ Menstrual irregularity	☐ Upset Stomach	☐ Stiff joints
☐ Tension	☐ Hot flashes	☐ Diarrhea	
☐ Ulcers	☐ Irritability	☐ Cold Sweats	

Please check if you have had any of the following:

☐ AIDS/HIV	☐ Bulimia	☐ Herniated Disc	☐ Rheumatoid Arthritis
☐ Anemia	☐ Cancer	☐ High Blood Pressure	☐ Stroke
☐ Anorexia	☐ Diabetes	☐ High Cholesterol	☐ Thyroid Problems
☐ Arthritis	☐ Gout	☐ Multiple Sclerosis	☐ Other
☐ Asthma	☐ Heart Disease	☐ Osteoporosis	

Stress can cause or accelerate spinal damage. On a scale of 1 to 10 (1 = none, 10 = extreme), rate your stress levels in the past 90 days: Occupational _____ Personal _____

Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture?

Poor 1 2 3 4 5 6 7 8 9 10 Excellent

On a scale of 1 to 10 (1 = poor, 10 = excellent), please rate your habits regarding the following:

Eating ____ Body Weight ____ Exercise ____ Sleep ____ Energy ____ Digestion ____ Overall Health ____

Do you have health goals? If so what are they? _____

_____

Patient/Guardian Signature: _____ Date: _____

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DISCLOSURE & CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays on me (or the patient named below, for whom I am legally responsible) by Dr. Steven Bourdage (the "Doctor") and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now, or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor.

I understand chiropractic care contributes to my overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I understand that some of the risks to exam and treatment include, but are not limited to fractures, disc injuries, sprains, increased symptoms, pain, no improvement of symptoms or pain, and in extremely remote conditions strokes. I do wish to rely on the Doctor to exercise judgment during the course of the procedure which the Doctor feels at the time, based on the facts then known, and is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

FINANCIAL POLICY

Thank you for choosing us for your chiropractic services. We are dedicated to helping you improve your health. **Full payment is due at the time of service** unless prior arrangements are made. We accept cash, checks, Visa, Mastercard, American Express and Discover. **PAYMENT OF THE FIRST VISIT IN FULL IS REQUIRED.**

INSURANCE ASSIGNMENT

You are considered to be a cash patient until our office "qualifies" your coverage to determine the extent of benefits under your insurance policy. All deductible payments MUST be made prior to submitting insurance claims. All co-payments and any other charges not covered by your insurance policy are to be paid at the time of service. This office does not file for or accept co-payment for secondary insurance coverage. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare program and/or other insurance.

The balance is **YOUR** responsibility, whether your insurance company pays or not. This office cannot guarantee that your insurance company will reimburse for the usual and customary charges submitted by this office, nor will we enter into any dispute with your insurance company over the amount of reimbursement. All insurance companies make clear that verification of coverage does not guarantee payment of benefits. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We provide the service of billing your insurance company as a convenience for you, free of charge. We may ask for your active assistance in the event that we experience difficulty collecting from your insurance company. If your insurance company has not paid your account in full within 90 days, the balance will automatically be transferred to you. Should you discontinue care for any reason other than discharge by the doctor, any and all balances due will become immediately payable in full, regardless of any claims submitted. You are responsible for notifying the office of any changes in your insurance coverage.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best care for you and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MISSED APPOINTMENTS

Our office policy is to charge for missed appointments and those cancelled without 24 hours notice. We reserve the right at our discretion, to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments, and/or by calling 24 hours in advance so another patient may be fit in.

PAYMENTS

It is the policy of this office that all services rendered are charged directly to you, the patient, and that ultimately, you are responsible for all services, including those not reimbursed by third party payors. Your balance may not exceed $200.00 at any time. All payments are due within 30 days of the monthly billing date. A service charge of 1.5% per month will be applied on any balance over 60 days. All accounts not paid within 90 days will automatically be put through your personal credit card for collection. Returned checks will be subject to an additional fee. If payment has not been received, you are in default and are responsible for any collection, filing, court, or attorney fees incurred in attempting to collect the amount or any future outstanding account balances.

I have read, or have had read to me the above consent and financial policy. I have had an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan and also agree to the financial policy. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment at this office. I have also received a copy of the Notice of Privacy Practices.

_____

Print Patient Name and Name of Legal Guardian if applicable

_____

Signature of Patient or Legal Guardian

_____

Date