ABOUT YOU

First Name _____ **Middle Name** _____

Last Name _____

Street Address _____

Address Line 2 _____

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

Mobile Phone ____-____-_____ **Work Phone** ____-____-_____ **Home Phone** ____-____-_____

Email Address_____

Date of Birth ____ / ____ / _____ **Gender** ☐ Male ☐ Female

Height _____'_____" **Weight** _____ lbs

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Number of Children _____ **Spouse's Name** _____

EMERGENCY CONTACT INFORMATION

Name _____

Phone ____-____-_____ **Relation to You** _____

INSURANCE INFORMATION

Do you have Insurance? ☐ Yes ☐ No

Insurance Name _____ **Phone** ____-____-_____

Address Line 1 _____

Address Line 2 _____

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

ID/Policy # _____ **Group #** _____

Insured's Name _____ **Insured's DOB** ____ / ____ / _____

REFERRAL INFORMATION

Referring Physician _____ **Contact Info** _____

Referring Patient _____

Are You Working with an Attorney? ☐ Yes ☐ No

How Did You Hear About Us?

☐ Word of Mouth ☐ Advertisement ☐ Social Media ☐ Direct Marketing ☐ Internet

REASON FOR VISIT

What is the date of your scheduled appointment? ____ / ____ / _____

How long have you had this complaint?

- ☐ Less than 5 days (Acute)
- ☐ Between 5-30 days (Sub Acute)
- ☐ More than 30 days (Chronic)

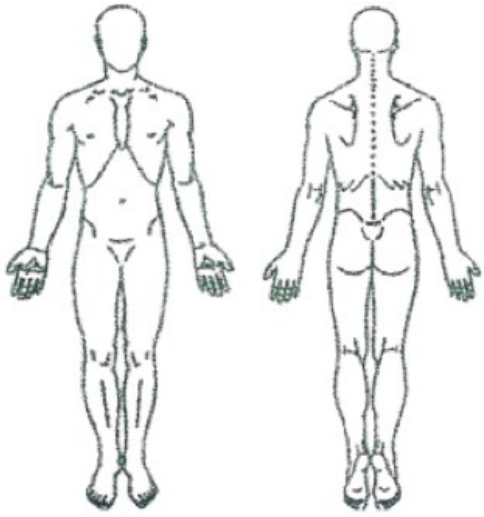
What caused this condition? _____

What is the date this condition began? (Skip if due to accident) ____ / ____ / _____

What terms describe your discomfort best? (aching, burning, tingling, etc.) _____

On the body diagrams to the right, please indicate your areas of symptoms by drawing in the appropriate symbols.

P - pain
N - numbness
W - weakness
S - shooting
A - aching



On a scale of 1 to 10, with 10 being the most severe, how would you rate your current level of discomfort?

None ***Unbearable***

0 1 2 3 4 5 6 7 8 9 10

How often do you feel this discomfort? ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

How has this complaint changed since the onset? ☐ Worsened ☐ Remained the same ☐ Improved

What activity is most significantly affected by this discomfort? (Explain) _____

_____

What treatment have you received for this condition up to now? _____

_____

What aggravates this condition? _____

What improves this condition or gives you relief? _____

Have other health care provider(s) performed tests related to this condition? _____

_____

Have you ever had any previous episodes of this condition? _____

_____

CURRENT HEALTH

Other than the information already provided, do you have additional health concerns involving any of the following?

Muscles, Bones, or Joints	☐ No	☐ Yes	**Explain:** _____
Nerves, Headaches, Dizziness, or Emotional	☐ No	☐ Yes	**Explain:** _____
Head, Eyes, Ears, Nose or Throat	☐ No	☐ Yes	**Explain:** _____
Heart, Blood Pressure, or Circulation	☐ No	☐ Yes	**Explain:** _____
Shortness of Breath, Coughing, Asthma or Lung Condition	☐ No	☐ Yes	**Explain:** _____
Stomach, Bowels or Digestive Conditions	☐ No	☐ Yes	**Explain:** _____
Genital, Bladder, or Urinary Conditions	☐ No	☐ Yes	**Explain:** _____
Diabetes, Thyroid or Glandular Conditions	☐ No	☐ Yes	**Explain:** _____
Skin or Bleeding Conditions	☐ No	☐ Yes	**Explain:** _____
Allergies or Sensitivities	☐ No	☐ Yes	**Explain:** _____

PERSONAL AND FAMILY HISTORY

Have you had any surgical procedures? ☐ No ☐ Yes **Explain:** _____

Are there any past illnesses or conditions we should be aware of? ☐ No ☐ Yes **Explain:** _____

Do you have a past history of accidents or trauma? ☐ No ☐ Yes **Explain:** _____

Are there any past illnesses or conditions we should be aware of? ☐ No ☐ Yes **Explain:** _____

Are you presently taking any medication? ☐ No ☐ Yes **Explain:** _____

Do you have a past family illness history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of? ☐ No ☐ Yes **Explain:** _____

WORK AND SOCIAL HABITS

Current work habits: select all that apply

- ☐ Permanently fully disabled
- ☐ Permanently partially disabled
- ☐ Cannot work due to current condition
- ☐ Full-time (20-40+ hours/week)
- ☐ Part-time (1-19 hours/week)
- ☐ Retired ☐ Student ☐ Homemaker ☐ Unemployed

Personal social habits: select all that apply

- ☐ Smoke or use tobacco products
- ☐ Drink alcohol
- ☐ Drink caffeine
- ☐ Use recreational drugs
- ☐ Other, to be discussed with doctor

Present exercise habits: select all that apply

- ☐ No current exercises
- ☐ Exercise daily
- ☐ Exercise 3+ times per week
- ☐ Cannot return to exercise due to current condition

Diet and nutrition habits: select all that apply

- ☐ Vegan or vegetarian
- ☐ Daily supplements
- ☐ Other

ADULT MEN'S HEALTH

Do you have pain or a lump in your scrotum or testicles?	☐ Yes ☐ No
Do you have an impaired libido (sex drive)?	☐ Yes ☐ No
Do you have discharge from your penis?	☐ Yes ☐ No
Do you have prostate issues?	☐ Yes ☐ No
When was your last prostate exam?	☐ Within the past year ☐ Between 1-4 years ☐ Greater than 5 years ☐ Never had a prostate exam ☐ Prefers not to answer or don't know
When was your most recent PSA (Prostate-Specific Antigen) blood test?	☐ Within the past year ☐ Between 1-4 years ☐ Greater than 5 years ☐ Never had a PSA blood test ☐ Prefers not to answer or don't know
What was your PSA (Prostate-Specific Antigen) level on your latest test?	☐ Normal or low ☐ Moderate ☐ High ☐ Never had a PSA level done ☐ Prefers not to answer or don't know

ADULT WOMEN'S HEALTH

Are you pregnant?	☐ Yes ☐ No
Are you nursing?	☐ Yes ☐ No
Are you taking birth control?	☐ Yes ☐ No
Do you experience painful periods?	☐ Yes ☐ No
Do you have irregular cycles?	☐ Yes ☐ No
Do you have breast implants?	☐ Yes ☐ No
Do you perform a regular self-breast examination?	☐ Yes ☐ No
Do you take Hormone Replacement Therapy?	☐ Yes ☐ No
Do you take oral contraceptives?	☐ Yes ☐ No
When was your last PAP/pelvic exam?	☐ Within the past year ☐ Between 1-4 years ☐ Greater than 5 years ☐ Never had a PAP or pelvic exam ☐ Prefers not to answer or don't know
When was your last mammogram?	☐ Within the past year ☐ Between 1-4 years ☐ Greater than 5 years ☐ Never had a mammogram exam ☐ Prefers not to answer or don't know
What was the date of your last menstrual period? (only answer if still menstruating)	☐ Within the past month or currently ☐ Within the past 1-3 months ☐ Greater than 3 months ☐ Postmenopausal ☐ Have not yet begun menstruation ☐ Prefers not to answer or don't know

INFORMED CONSENT TO TREATMENT

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Signature: _____ **Date:** ____ / ____ / _____

Informed Consent

You have the right to be informed about your condition and the possible options for treatment. This includes knowing the risks and benefits related to each treatment option. This information will help you make an informed decision about whether or not to follow the recommended care.

When a patient seeks chiropractic care it is important for doctor and patient to be working towards the same goal. Chiropractors focus on finding and removing subluxations. Subluxations are misalignments of joints in the body that prevent normal movement. This can change nerve function and hinder the body's natural ability to heal. We remove these subluxations through the use of adjustments. An adjustment is a specific thrust into the misaligned joint that helps restore normal motion. This allows the nervous system to work better at keeping you healthy.

In addition to the many benefits of chiropractic care, there are also some risks. These risks should be considered when making the decision to receive chiropractic care. All health care procedures have some risk associated with them. Symptoms you may feel after starting care include muscle spasm, bruising, nausea, dizziness, fatigue and soreness. These should subside after your first 3-5 visits. Severe risks such as nerve injury, fracture, and stroke are very rare but can occur. The technique used in this office is very gentle and greatly decreases these risks. There is no guarantee that the treatment will provide the expected or desired outcomes. Your lifestyle, including diet, exercise and stress level, will affect your results.

If, at any time, you have questions or concerns regarding your treatment please contact our office. The doctor will be happy to discuss them with you.

Consent for Chiropractic Care

I have read and understand the purpose of chiropractic care and the potential risks involved. I also understand that the doctor does not guarantee my response to care. Other treatment options have been explained to me and my questions about this consent form have been addressed.

I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND WHAT I HAVE READ. I CONFIRM THAT ALL MY QUESTIONS HAVE BEEN ANSWERED.

I CONSENT TO RECEIVE THE CHIROPRACTIC CARE DEEMED NECESSARY BY THE DOCTOR.

DATED THIS _____ DAY OF _____, 20_____, WARRENTON, VA

_____ _____

Print Patient Name Patient Signature

_____ _____

Print Doctor Name Doctor Signature

Parental Consent for Minor Patient:

Patient Name: _____

Patient age: _____ DOB: _____

Printed name of person authorized to sign for Patient:

_____

Signature: _____

Relationship to Patient: _____

FINANCIAL POLICY AND AGREEMENT

Advantage Chiropractic and Massage Therapy

I, the undersigned, in consideration of the office's services, agree to the following terms:

Definitions, in this agreement, "Office" and "Clinic" shall refer to Douglas Smith, P.C., D.B.A. Advantage Chiropractic and Massage Therapy located at 400 Holiday Court, Suite 106, Warrenton, VA 20186. "Financial Policy" or "Agreement" shall refer to this document. "Payer" shall refer to a third-party payer/ insurance company.

Authorization to Sign My Name on Payments; Transfer or Credit Balances. I authorize the Office to endorse or sign my name on any and all payments listing me as a payee which are received by the Office for payment of Charges Incurred by me, my spouse, or my dependents. In such cases, my printed name followed by the phrase, "(by Advantage Chiropractic and Massage Therapy)," shall serve as a property authorized endorsement. I further authorize the Office to apply any credit balances on my Personal Responsible Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

Personal Responsibility for My Charges. I understand that I remain personally responsible for my Charges and that at any time, I can request a copy of my total charges from the Office. Except where provided otherwise by law or by contract, I agree to pay the full amount of my Charges to the Office promptly upon its demand. I understand that the Office's Assignment does not constitute an agreement by the Office to await payment of my Charges. I agree that any delay by the Office in making demand for payment, any delay in paying the full amount of my Charges, and any partial payments received by the Office towards my Charges, shall not constitute acceptance of any installment payment regardless of any such terms or restrictions indicated on, or included with any payments. I also agree that my account with your Office shall be constructed as in "default" on the earlier of the following dates; (a) a payer fails to pay any or all of the charges in full and directly to the Office upon receipt of those charges within thirty (30) days or the period established by the earliest prompt deadline applicable to the payer (whichever occurs earlier), (b) I do not pay any and all of these charges in full within fourteen (14) days of request, or (c) the office attempts to charge my credit card with compliance with a written arrangement, but the charge is declined or not approved.

Personal Responsibility for Verify the Limitations in My Coverage; Financial Responsibility for Non-Covered Charges. I understand that in any given situation, Payer may initially refuse to make payment to the Office, may delay payment for an indefinite or unreasonable amount of time, or may actually request a refund from the office after making payment, and do so either in whole or in part with respect to any given Charge incurred at the Office (collectively, "Deny Payment"). For example, without limiting this Agreement, I understand that a Payer may Deny Payment, stating that the Charge is "not a covered benefit" under its policy or exceeds some other limitation. I further understand that a payer may Dent Payment stating that the individual provider who actually renders the treatment or procedure is out-of-network. I also understand that a Payer may claim, based on internal criteria, that a particular Charge is or was not medically necessary or was not sufficiently documented, and should therefore be denied or down coded. I also understand that a Payer may require certain Charges to be pre-certified or pre-authorized. In the event that my condition arose from an accident, I further agree to the terms of the Office's Auto/Work Comp Advance Beneficiary Notices as applicable. I understand that there may be many other situations where a Payer may Deny Payment based on a particular contractual term applicable to me or to the Office (collectively, "Terms of Non-Coverage"). To the extent permitted by law or by contract, I agree that I am solely and exclusively responsible for verify all Terms of Non-Coverage prior to incurring any Charges at the office. I agree that if I have any questions about the Terms of Non-Coverage, I can request copies or the Offices verification (e.g. eligibility, pre-authorization) forms to gain further understanding. I agree that should the Office assist me in any way in the verification, pre-authorization, or billing process, I assume the risk that the Payer and/or the Office may in my opinion not accurately understand and/or communicate the Terms of Non-Coverage and/or bill my Charges to my Payers. Should any Payer Deny Payment, or should any Payer be likely to Deny Payment as determined by the Office in its sole discretion, I agree that I am personally, fully, and immediately responsible for the portion of my Charges denied or likely to be denied. In no event shall I hold the Office responsible or liable in any of the forgoing instances.

Directions to the Office to Apply the Lowest Mandatory Fee Reduction When Two or More Payers Are Involved. Unless otherwise agreed to in writing, I authorize the Office to submit my Charges, as well as a copy of the Assignment & Lien, to any

and all Payer, including without limit in accident cases my health benefit plan, but not including Medicare. Notwithstanding the foregoing. In the event that the Office determine in its sole discretion that it has any reasonable basis for either submitting or not submitting my Charges and/or other documentation to a Payer, I hereby authorize the Office to take such action without condition or restriction. I understand that some or all of these Payers may utilize fee schedules which (a) the Office has agreed to accept, directly with said payers in writing, or (b) law expressly imposes on the Office to accept (collectively, "Mandatory Fee Reductions"). I further understand that the Mandatory Fee Reductions imposed on the Office with respect to one Payer may exceed the Mandatory Fee Reductions imposed on the Office with respect to another Payer. In such an event, I hereby authorize and direct the Office insofar as permitted by law to apply the lower of the two Mandatory Fee Reductions to its Charges. I further agree that in the special event that Mandatory Fee Reductions are Imposed on the Office by virtue of laws which regulate or restrict "balance billing," I hereby waive the application of such laws to the extent permitted by the law. In the event that no Mandatory Fee Reductions are actually Imposed on the Office with respect to a Payer, I authorize and direct the Office to collect up to its full Charges from such Payer.

Miscellaneous Provisions. Except as provided int his paragraph, this Agreement shall not be modified or revoked without the expressed, written consent of the office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this agreement. I agree that each and every provision of this agreement is reasonably necessary. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect. This Agreement shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Agreement, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum incontinence. I further waive any statute of limitations which may apply in any action based upon this Agreement. I have reviewed the Office's "Assignment & Lien". Health Insurance Election, and, if applicable, Auto/Work Comp Advance Beneficiary Notices, and further agree to the forms and definitions set forth in these documents as applicable. Said documents are incorporated herein by reference. In the event that my condition is related to an accident, including without limit automobile accident, I understand that there will be an administrative fee necessary to cover the costs of verifying multiple Payers, filling and termination liens, and submitting notices of same to Payers.

I have read, understood, and agree to the terms of this Agreement.

Patient Name (print): _____

Date: _____/_____/_____

Patient Signature: _____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print):

_____

Parent/Guardian Signature: _____

Date: _____/_____/_____