ChiroCenters.com
Referred by Friends...Preferred by Patients

CHIROPRACTIC CENTERS OF VIRGINIA AT...
Harbour Pointe • 6003 Harbour Park Dr. • Midlothian, VA 23112 • (804) 739-7700
Courthouse Commons • 10002 Courtview Ln., Ste. 100 • Chesterfield, VA 23832 • (804) 748-5748
Short Pump • 3037 Lauderdale Dr. • Richmond, VA 23233 • (804) 360-2447
Midlothian • 14431-D Sommerville Court • Midlothian, VA 23113 • (804) 745-7822
Colonial Heights • 209 Temple Ave • Colonial Heights, VA 23834 • (804)-523-8023

Registration Information

Name : _____
First *Middle Initial* *Last*

Address: _____

_____
City *State* *Zip*

Home Phone: Other Phone: E-mail Address:

SSN#: - - Date of Birth :_____/_____/_____ Gender: ❑ M ❑ F

Are you? ❑ Single ❑ Married ❑ Divorced ❑ Other Spouse's Name:

Employer: _____ Occupation: _____

Address: _____

_____
City *State* *Zip*

Work Phone: ( ) - Fax: ( ) - E-Mail Address:

Insured Information (if other than patient)

Name :
First *Middle Initial* *Last*

Address:

City *State* *Zip*

Home Phone: ( ) - Fax: ( ) - E-mail Address:

SSN#: - - Date of Birth :_____/_____/_____ Gender: ❑ M ❑ F

How did you find us?
❑ Patient? If yes, who?
❑ Other Doctor? If yes, who?
❑ Other? Explain:
❑ Yellow Pages?
❑ Sign?
❑ Mailing?

1. What date did your symptoms begin? _____/_____/_____
2. Have you had these symptoms before? _____ If yes, when? _____
3. How did this happen?

4. Is this injury work or auto accident related? ❑ No ❑ Yes

5. Are your arms or legs involved? ❑ No ❑ Yes

6. Please describe your chief complaint _____

_____

7. What makes it better or worse? _____

8. Please list all medications prescribed to you within the last year _____

_____

9. What kind of activities do you participate in during your free time? _____

Have you ever had or are you having problems with any of the following?

❑ No ❑ Yes	Headaches	If yes, how often and when?	_____
❑ No ❑ Yes	Dizziness	If yes, how often and when?	_____
❑ No ❑ Yes	Sinus pain	If yes, how often and when?	_____
❑ No ❑ Yes	Neck pain	If yes, how often and when?	_____
❑ No ❑ Yes	Upper back pain	If yes, how often and when?	_____
❑ No ❑ Yes	Mid-back pain	If yes, how often and when?	_____
❑ No ❑ Yes	Low back pain	If yes, how often and when?	_____
❑ No ❑ Yes	Shoulder pain	If yes, how often and when?	_____
❑ No ❑ Yes	Chest pain	If yes, how often and when?	_____
❑ No ❑ Yes	Heart	If yes, how often and when?	_____
❑ No ❑ Yes	Stomach	If yes, how often and when?	_____
❑ No ❑ Yes	Bladder	If yes, how often and when?	_____
❑ No ❑ Yes	Liver	If yes, how often and when?	_____
❑ No ❑ Yes	Kidney	If yes, how often and when?	_____
❑ No ❑ Yes	Colon	If yes, how often and when?	_____
❑ No ❑ Yes	Hip	If yes, how often and when?	_____
❑ No ❑ Yes	Circulation	If yes, how often and when?	_____
❑ No ❑ Yes	Prostate	If yes, how often and when?	_____
❑ No ❑ Yes	Breast	If yes, how often and when?	_____

❑ No ❑ Yes 1. Have you ever been in an accident?

❑ No ❑ Yes 2. Have you ever been hospitalized or had any surgery?

❑ No ❑ Yes 3. Have you ever had measles, mumps, rheumatic fever, sexually transmitted disease or any other type of infection?

❑ No ❑ Yes 4. Have you or your family ever had cancer?

❑ No ❑ Yes 5. Have you or a family member ever been diagnosed with diabetes?

❑ No ❑ Yes 6. Has any family member ever had neck, back, or spinal problems?

❑ No ❑ Yes 7. Do you drink alcohol, smoke cigarettes, or ever use any recreational drugs?

❑ No ❑ Yes 8. If female, any possibility of currently being pregnant?

If you answered "yes" to any of the items above, please explain: _____

Patient Signature_____ Date_____

Parent or Guardian_____ Date _____

OFFICE POLICY FOR FINANCES AND INSURANCE

1. We will need to verify coverage on all patients prior to beginning treatment or the patient will be financially responsible for all costs until such verification of coverage occurs. We will provide you with a copy of your verification of coverage from your third party payor. We ask that you call your insurance provider to verify its accuracy.

2. Should your insurance provider quote your coverage differently than what was provided to us, as noted on the verification of coverage, please notify us as soon as possible.

3. You will receive copies of EOB's (explanation of benefits/payments to your Chiropractor) from your insurance company. They will come in the mail. Please open each one and compare what the EOB states as your financial responsibility vs. the amount you pay each visit in our offices. Any differences between the two should be brought to our attention immediately. If additional amounts are due, please be prepared to pay that amount at your next visit. After reviewing the EOB, please place it into the manila folder that was given to you on your first visit, so that you will have all your Chiropractic records in one place.

4. We will file all claims as a courtesy and/or requirement for third party reimbursement, however, you may still be held responsible for payment should such claim be denied.

5. We allow up to 60 days before claims will be the responsibility of the patient to pay. Interest on the claims will not occur until 30 days past the patient's responsibility date or thirty days after denial of third party payment, which ever occurs first.

6. Statements will only be sent if there is a balance due by the patient.

7. Responsibility for obtaining and maintaining referrals for HMO plans is that of the patient. We cannot alter or modify dates of service (or anything else) to accommodate improper filing procedures. If coverage is verified after a treatment date in which the patient paid in full, we will file that claim as a courtesy and the patient will be eligible for a refund after we receive payment for such date.

8. Our office will need to be notified immediately if there is any change in the following: health insurance, patient address, patient home telephone number, coverage termination or cancellation or any other reason that may affect third party reimbursement.

9. Non-compliance for payment due may result in a $25.00 late payment/no payment and/or interest charges.

10. Deductibles and all co-payments are expected at the time of service and may be paid ahead.

11. Unless other arrangements have been made, if a patient's treatment plan is greater than once every 3 weeks, the patient will no longer be eligible for health insurance assignment. Most health insurance considers this to be maintenance care and does not reimburse for this. You may still be eligible for insurance reimbursement, however, we will ask that the patient pay us and then the patient can submit the bill to their insurance carrier for direct reimbursement.

12. This office does not promise that an insurance company will pay for usual and customary charges of this office, nor will this office enter into any dispute with an insurance company over reimbursement or the amount of reimbursement.

13. I understand, should additional information be asked from Colonial Heights Wellness Center (i.e. notes), that I would allow 15 working days for such requested information.

14. I have read over and agree to the financial considerations for treatment costs.

Patient Signature: _____ Date _____

Parent or Guardian: _____ Date _____

FINANCIAL CONSIDERATIONS

1. Your first visit to our office will consist of an orthopedic-neurological examination and x-rays, if medically necessary. You may, also, receive palliative therapy. Therapies for most conditions include interferential stimulation, ice/heat and/or therapeutic activities.
2. On your second visit the doctor will provide you with a report of findings and recommendations for care. After meeting with the doctor, our receptionist will review the financial obligations of your care. Chiropractic adjustments will only be performed after notification and mutual agreement of financial costs, treatment plan and terms of care.
3. A schedule of costs for procedures is provided for you below:

Examination:	New Patient Brief Exam	= $90.00
	New Patient Expanded Exam	= $155.00
Re-examination:	Established Patient Brief Exam	= $45.00
	Established Patient Extended Exam	= $95.00
Office Visit/Adjustment:	Adjustment (1 to 2 regions)	= $55.00
	Adjustment (3 to 4 regions)	= $60.00
	Adjustment (5 or more regions)	= $65.00
	Adjustment (extremities)	= $35.00
X-rays: Technical Component (Per film)	Cervical x-ray	= $22.00
	Thoracic x-ray	= $28.00
	Lumbo-Pelvic x-ray	= $28.00
	Extremity/Individual Bone (2-3 views)	= $22.00 to $28.00
X-Rays: Professional Component (Per film)	Cervical (series)	= $23.00
	Thoracic (series)	= $27.00
	Lumbar (series)	= $27.00
Therapy:	Interferential Stimulation	= $25.00
	Moist Heat/Ice	= $12.00
	Therapeutic Activities	= $30.00
	Therapeutic Exercises/Stretching	= $30.00

May include one or more of the following:

- Manual lumbar or mechanical cervical traction
- Soft tissue/muscle release
- Strength Development
- Vibrating fascia release
- Others

Costs for care:	Average visit during intensive care and phase 1-	$150.00
	Average visit during phase 2 and supportive care -	$125.00

Durable Goods: Must be paid upon receipt. Remember these goods may not be returned for refund or credit.

I have read and understand the cost of services provided. These prices are subject to change without notice.

Patient Signature_____Date_____

Parent or Guardian_____ Date_____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and / or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Colonial Heights Wellness Center all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect for seven years or until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

I have read your authorization and legal assignment of benefits and agree to its terms. My signature authorizes you to disclose my PHI in the manner described above and acknowledges that I will receive a copy of this completed form for my own records.

Printed Patient Name	Signature	Date
Printed Parent or Guardian Name	Signature	Date

CONSENT TO TREATMENT

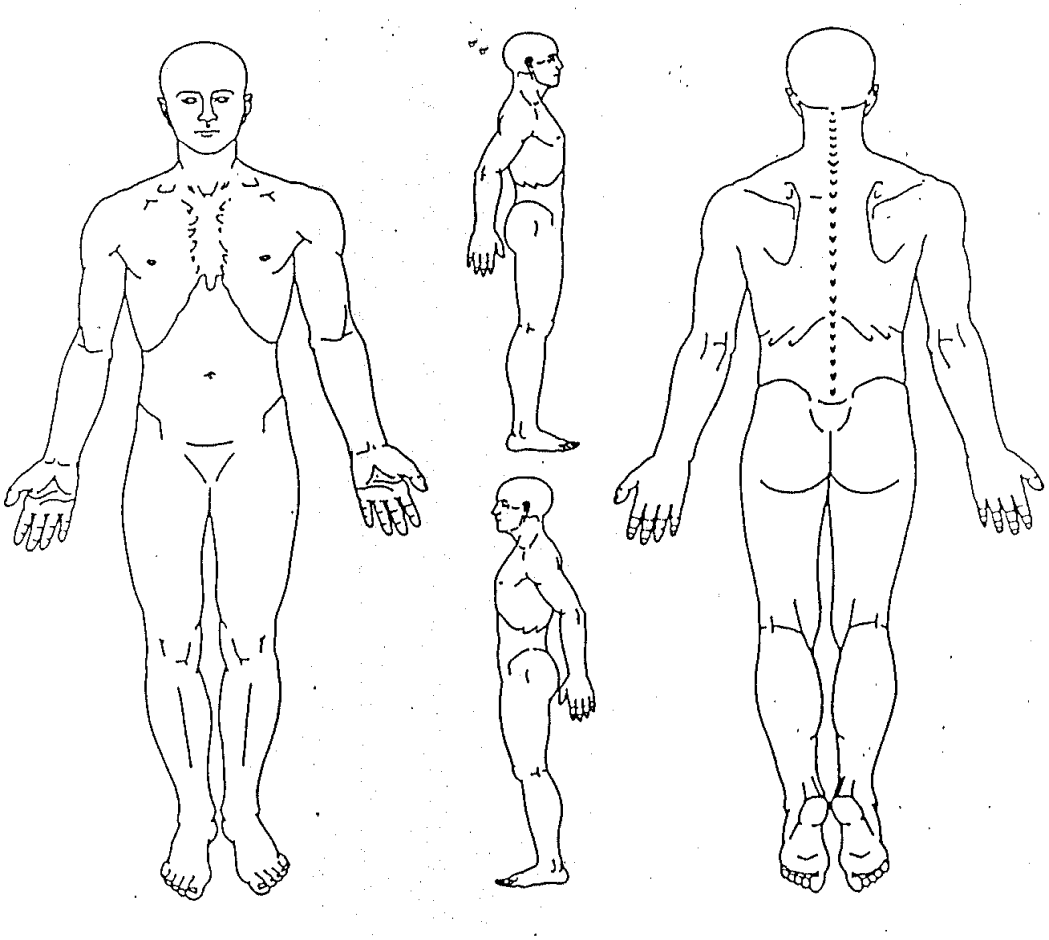
I hereby certify all information provided on the patient registration information form is complete, truthful and to the best of my knowledge. I have received and read the notice of privacy practices for Colonial Heights Wellness Center. I authorize Colonial Heights Chiropractic Wellness Center to perform Chiropractic manipulations, therapeutic modalities, x-ray examinations, consulting services, diagnostic procedures and any other procedure necessary for treatment. I understand that any outstanding account balance will be subject to 18% annual interest rate. I also understand that any late payments will be subject of a $25 service charge per billing cycle. In addition, I understand that any outstanding balance owed to ColonialHeights Wellness Center that becomes delinquent will result in legal action to collect the outstanding balance and that I will incur filing fees, attorney fees or whatever fees may occur as a result of my delinquent account. I understand these fees will total no less than 33 1/3% of monies owed. I also understand that if an appointment is cancelled or missed without 24-hour notification, that I will incur a $25 fee, as another patient may have needed the time that I was scheduled. I have also chosen to receive chiropractic care for my specific condition understanding my other options for treatment as well as the risks involved. Furthermore, any returned checks will automatically incur a $35 service charge. If I am not of legal age my parent or guardian will in turn guarantee my obligations to Colonial Heights Wellness Center, and that the patient or guardian consents to treatment performed by Colonial Heights Wellness Center, for the minor (patient).

Printed Patient Name	Signature	Date
Printed Parent or Guardian Name	Signature	Date

Please use the appropriate letters below to indicate the type and location of your sensations right now.

A=ACHE B=BURNING S=STABBING

N=NUMBNESS P=PINS & NEEDLES O=OTHER



Please rate the severity of your pain by placing a straight up and down line on each line below.

RIGHT NOW No pain |----------| Unbearable Pain

BEST in the past week No pain |----------| Unbearable Pain

AVERAGE in past week No pain |----------| Unbearable Pain

WORST in past week No pain |----------| Unbearable Pain

_____ _____

Patient Signature Date

_____

Print Name