LoMonaco Healthcare PLLC. Family Chiropractic

Name (last)______________________(first)___________________________(mi)______ Date__________

Address____Zip____________________

Home Phone_______________________ Cell #______________________Work#_________________________

Birth Date___________________________Age____________ Height________ Weight____________________

Do you use tobacco?_______ email address:_____________________________________

Marital Status Single Married Other

Emergency Contact: _____________________________ Phone #______________________________________

Whom may we thank for referring you? ____

What type of work/school do you do?____

Primary complaint? __________________ Specific location:_____________________________________

Quality: achey, burn, cramp, dull, sharp, shooting, stabbing, radiating, sting, tender, throbbing, other____

Severity: on a scale of 0(best) to 10(worst)____

Onset: when did this start?____

Setting: When does it bother you? sitting, standing, bending, lifting…other_________________

What makes it better? ____

What makes it worse? ____

Have you had prior treatment for this problem?____

Secondary complaint?___________________________Specific location:___________________________________

Are these conditions affecting your daily activities of living? NO YES

Were any of these tests performed? Xrays MRI CT Scan EMG Other __________________________

Do you or any family members have a history of back pain? ____

If so, explain ____

Do you have any vomiting, nausea, fever, chills, or unexplained weight loss or weight gain? __________

Have you had any surgeries? ____

____

List current medications and supplements? ______________________________________

____

Have you had any… CAR ACCIDENTS FALLS BROKEN BONES FENDER BENDERS

Have you ever had chiropractic care before? If so, when? ____________________________

Women: Is there any reason to believe that you may be pregnant? YES NO

Please circle any other health problems/conditions that you HAVE or HAVE HAD in the past:

Headaches	**Low Back Pain**	**Diabetic problems**
Sinus problems	**Skin problems**	**Liver problems**
Weight problems	**Pins/needles in arms/hands**	**Pain in legs and feet**
Heart problems	**Allergies**	**Ear/nose/throat problems**
Stomach problems	**Gall Bladder problems**	**Bladder/Continence problems**
Kidney problems	**Unexplained Fatigue**	**Pain b/w the shoulder blades**
Pain in joints	**High blood pressure**	**Thyroid problems**
Menstrual problems	**Sleeping problems**	**Bowel problems**
Neck Pain	**Eye problems**	**Constipation**
Fatigue	**Asthma**	

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TERMS OF ACCEPTANCE

The goal of the chiropractor is not to diagnose/treat any disease but to locate, analyze and correct vertebral subluxations. The purpose of care is to improve joint mechanics and to restore the innate healing mechanisms of the body via a nervous system free of irritation/interference. I consent to the customary examinations, tests and procedures performed at LoMonaco Healthcare, LLC. and to routine chiropractic treatment ordered or administered by my chiropractor or other clinic staff. I recognize that the practice of chiropractic is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of services administered to me in connection with this Agreement. I understand as with any health care procedure that certain complications may rarely occur such as fractures, disc injuries, muscle or vertebral strains, arterial dissection, or others.

_______________INITIALS

FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all charges incurred at this clinic. Not limited to but including deductible, co-payment and any services rejected by my insurance company.

> **Financial Policies:** **We will try our best to inform you of your insurance benefits, however, we cannot be held responsible for what your insurance company tells us over the phone. Your EOB (Explanation of Benefits) is what we legally have to go by.**

_______________INITIALS

ASSIGNMENT

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional/chiropractic expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the services rendered by this clinic. A photocopy of this assignment shall be considered as effective and valid as original.

_______________INITIALS

RELEASE OF INFORMATION

I authorize this clinic to release any patient information from my case to any insurance company, adjuster, and/or attorney involved in my case; and hereby release this clinic of any consequence thereof.

_______________INITIALS

MISSED APPOINTMENT POLICY

LoMonaco Healthcare PLLC. Chiropractic Clinic reserves the right to bill any patient for a missed appointment with no advance notice of cancellation or reschedule.

__________________INITIALS

SIGNATURE_____________________________________DATE_______________

WE ARE GLAD YOU CHOSE OUR OFFICE FOR YOUR CHIROPRACTIC NEEDS!

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that LoMonaco Healthcare Chiropractic Clinic's "Notice of Privacy Practices" has been provided to me.

I understand that I have a right to review LoMonaco Healthcare Chiropractic's Notice of Privacy prior to signing this document. LoMonaco Healthcare Chiropractic's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of LoMonaco Healthcare Chiropractic. The Notice of Privacy Practices for LoMonaco Healthcare Chiropractic is also provided on request at the main administration desk of this practice. Notice of Privacy Practices also describes my rights and LoMonaco Healthcare Chiropractic's duties with respect to my protected health information.

LoMonaco Healthcare Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the offices and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

______________________________________ ______________________

Signature of Patient or Personal Representative Date

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Print Name of Patient or Personal Representative

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Description of Personal Representative's Authority