Welcome to Ashburn Village Chiropractic!

Ashburn Village Chiropractic • 44110 Ashburn Shopping Plaza, Suite 158, Ashburn, Virginia 20147 • (703)723-6800

Last Name_____ First Name _____ MI _____PRE/Suffix_____

Address _____ Unit or Apt # _____

City_____ State _____ Zip _____

E-Mail _____ Home Phone _____ - _____ - _____

Work Phone_____ - _____ - _____ Cell Phone _____ - _____ - _____ Best # ? ◯ ◯ ◯

Patient Age _____ Patient Date of Birth _____/_____/_____ SEX: M ☐ F ☐

Single ◯ Married ◯ Widowed ◯ Separated ◯ Divorced ◯ Soc. Sec#_____

Patient Employed by _____ Occupation _____

Whom may we thank for referring you? _____

Notify in Case of emergency _____ Phone _____

Primary Insurance

(If you have a copy of your insurance card, you may skip this section)

Person responsible for Account _____
First Name Last name Initial

Relation to Patient _____ Birth Date _____ Soc. Sec# _____

Address (if different from patient) _____Phone _____

City _____ State _____ Zip _____

Person Responsible employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Phone _____

ID# _____ Group # _____

Name of other dependents under this plan _____

Reason for Visit

Have you ever seen a chiropractor ? Yes ◯ No ◯ If yes, when and why? _____

Your reason for *this* visit: _____

Please describe your current pain and its location: _____

When did the symptoms begin (date)? _____ Have you ever had a similar condition in the past? _____

Is the pain getting: Worse ☐ Better ☐ Same ☐ Comes and goes How often do you have this pain? _____

Have you been treated by a medical physician for this condition? _____

If so when and where? _____

Activities or movements that are difficult/painful to perform: Sitting ☐ Walking ☐ Bending ☐ Lying down ☐ Lifting ☐

Type of Pain: Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Burning ☐ Tingling ☐ Numbness ☐

Is pain interfering with: Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐

Other description: _____

Health History

Please list any medication (including pain killers) you are taking: _____
_____

Please list any serious injuries of surgeries you have had in the last 10 years:

	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Other Serious Injuries	_____	_____
	_____	_____

Women: Are you pregnant? Y ☐ N ☐ If so, how far along? _____ Nursing? Y ☐ N ☐

Medical Conditions

- ☐ Heart Attack/Stroke
- ☐ Congenital Heart Defect
- ☐ Alcohol/Drug Abuse
- ☐ Fainting Seizures/Epilepsy
- ☐ Shingles
- ☐ Psychiatric Problems
- ☐ Difficulty Breathing
- ☐ Hepatitis
- ☐ Anemia
- ☐ Arthritis
- ☐ Frequent Neck Pain
- ☐ Jaw Pain
- ☐ Wrist Pain
- ☐ Shoulder Pain
- ☐ Arm Pain
- ☐ Leg Pain
- ☐ Lower Back Problems
- ☐ HIV Positive/ AIDS
- ☐ Ringing in Ears
- ☐ Severe/ Frequent Headaches
- ☐ Diabetes/tuberculosis
- ☐ Dizziness
- ☐ Emphysema/Glaucoma
- ☐ Kidney Problems
- ☐ Artificial Bones/Joints
- ☐ Cancer
- ☐ Ulcer/Colitis
- ☐ Gout
- ☐ Numbness, where? _____
- ☐ Tingling, where? _____
- ☐ Muscle spasm, where? _____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful treatment. If there is any change in my medical status, I will inform the chiropractor.

I authorize my insurance company to pay the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the chiropractor to release all information necessary to secure payment of the benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. Patient agrees that if his/her account is sent to collection, then patient will be responsible for Ashburn Village Chiropractic's costs of collection, including attorney's fees in the amount of 25% of the principal amount outstanding.

Signature _____ Date_____

Payment is due in full at time of treatment unless prior arrangements have been approved.

Ashburn Village Chiropractic

Patient Financial Policy

We are committed to providing you with the best possible care, and will help you receive your maximum allowable insurance benefits. However, we need your assistance and your understanding of our payment policy. Your insurance contract is between you, your employer and the insurance company. Not all services are covered by all contracts.

We participate and accept assignment from most major payers, which means covered charges, will be paid directly to us. If we do not participate in your insurance plan, you my still choose to be seen by the practice. As a courtesy to you, we will file a claim with your insurance carrier on your behalf. Any remaining balance will be billed to you once we have received a remittance from your insurance carrier.

Due to current federal and insurance regulations, ***all*** co-payments are collected at time of service, unless prior arrangements have been made. We accept cash or checks and for you convenience, Visa, MasterCard, Discover, American Express and Debit Card. Additional fees, which typically are not covered by insurance plans will be charged for services such as copying of medical records, and completion of disability forms. A fee of $30.00 will be charged for checks returned for insufficient funds. Patient agrees that if account is sent to collection they will be responsible for Ashburn Village Chiropractic's costs of collection, including attorney's fees in the amount of 25% of the principal amount outstanding. We encourage you to contact us promptly for assistance in the management of your account. We are here to help you and will be happy to answer any questions you may have about your treatment or account.

Patient Financial Agreement

I hereby authorize Ashburn Village Chiropractic to apply for benefits on my behalf for all services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any information necessary to my insurance company to determine benefits for services rendered. I request that payment of authorized benefits be made payable directly to Ashburn Village Chiropractic on my behalf.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read the above Patient Financial Policy and have provided the Practice with true and correct insurance information. I will notify you of any changes in my health insurance coverage.

A copy of this agreement may be used in place of the original.

_____ _____

Signature of Patient, Policy Holder or Legal Guardian Date

_____

Printed Name