PERSONAL INFORMATION

Today's Date: _____

PATIENT INFORMATION

Name (First, MI, Last):_____Preferred Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Home Phone:_____ Mobile:_____ Work:_____
Email:_____
Marital Status: (Single/Married/Other)_____ Sex: M /F Date of Birth: _____

Type of Work: _____ Employer:_____

How did you hear about us? _____ (Family/Friend/Co-Worker/Doctor/Other)

EMERGENCY CONTACT INFORMATION

Name (First, MI, Last):_____
Home Phone: _____ Mobile: _____
Relationship: Child / Parent / Spouse / Other: _____

Primary Care Physician:_____ Phone: _____

FINANCIAL INFORMATION
O Medicare OR **O** Self Pay

MEDICARE INFORMATION
Policy Number: _____
SECONDARY INFORMATION
Insurance Name: _____
Policy Number: _____
Relationship to Insured: Self / Spouse / Parent / Child / Other

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For Office Use Only

Weight: _____ BP: _____/_____
Height: _____ HR: _____

FBG Chiropractic & Wellness

PATIENT HISTORY

CURRENT CONDITION

Describe Major Complaint: _____

Describe Secondary Complaint: _____

When did this complaint begin? _____

How long has this complaint persisted? _____

Does this complaint radiate/shoot to any areas of your body? No/Yes (Describe) _____

Does anything make this better? Ice / Heat / Movement / Rest / Medication / Other:_____

What activities are being affected by this complaint? _____

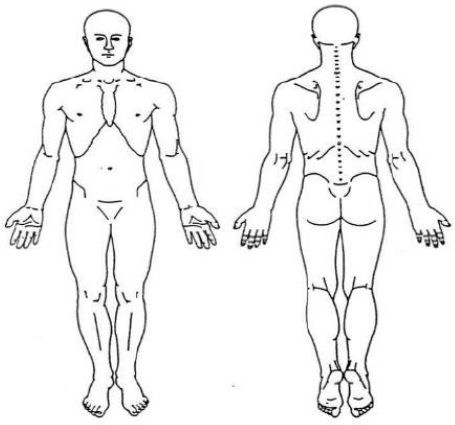
Have you received any treatment? None / DC / MD / PT / Massage / Other: _____

Have you had diagnostic testing? X-rays / MRI / CT / Other: _____ When/Where _____

Please mark an X on pictures below at any areas of pain

Severity (**0**=*no pain* and **10**=*severe*): 0 1 2 3 4 5 6 7 8 9 10

Is your pain now better or worse since onset? _____



Frequency: Constant / Intermittent / Off & On / Other

Quality of Pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff / Sore / Numbness / Tingling / Other: _____

_____

HEALTH HISTORY

Surgeries: None / Yes (describe): _____

Family History (Major health problems): _____

Allergies to Medications: _____

Current Medications & Supplements: _____

_____

Multivitamin (Yes / No) _____

Daily Water Intake? _____

Position When Sleeping: _____

Review of Symptoms

General: (constitutional)
- ❑ Recent weight change
- ❑ Fever
- ❑ Fatigue
- ❑ None in this category

Musculoskeletal:
- ❑ Low Back Pain
- ❑ Mid Back Pain
- ❑ Neck Pain
- ❑ Arm Problems
- ❑ Leg Problems
- ❑ Painful Joints
- ❑ Stiff/Swollen Joints
- ❑ Sore/Weak Muscles
- ❑ Muscle Cramps/Spasms
- ❑ Broken Bones
- ❑ None in this Category

Respiratory:
- ❑ Difficulty Breathing
- ❑ Persistent coughing
- ❑ Asthma or Wheezing
- ❑ Lung Problems
- ❑ None in this category

Gastrointestinal:
- ❑ Abdominal Pain
- ❑ Blood in stool
- ❑ Change in Bowell Movements
- ❑ Painful bowel movements
- ❑ Nausea or Vomiting
- ❑ Constipation
- ❑ Frequent diarrhea
- ❑ None in this category

Cardiovascular:
- ❑ Chest pains
- ❑ Rapid heartbeat
- ❑ Blood pressure problems
- ❑ Swelling of hands
- ❑ Heart problems
- ❑ None in this category

Skin and Nails:
- ❑ Rash or itching
- ❑ Change in skin color
- ❑ Non-healing issues
- ❑ Change in hair or nails
- ❑ Change in mole appearance
- ❑ None in this category

Endocrine, Hematologic, & Lymphatic:
- ❑ Thyroid Problems
- ❑ Diabetes
- ❑ Excessive urination
- ❑ Cold extremities
- ❑ Heat or Cold intolerance
- ❑ Swollen Glands
- ❑ Glandular/hormone issues
- ❑ Dry skin
- ❑ Easily bruise or bleed
- ❑ Anemia
- ❑ None in this category

Ears, Nose, & Throat:
- ❑ Bad breath or bad taste
- ❑ Bleeding gums/sores
- ❑ Swollen throat
- ❑ Swollen glands in neck
- ❑ Earache /Ringing/Drainage
- ❑ Sinus/Allergy problems
- ❑ Nose bleeds
- ❑ Hearing loss
- ❑ None in this category

Neurological:
- ❑ Numbness or tingling
- ❑ Loss of feeling
- ❑ Dizziness
- ❑ Frequent Headaches
- ❑ Convulsions/seizures
- ❑ Tremors
- ❑ Stroke
- ❑ None in this category

Genitourinary:
- ❑ Sexual difficulty
- ❑ Kidney stones
- ❑ Burning/painful urination
- ❑ Change in force of urination
- ❑ Frequent urination
- ❑ Blood in Urine
- ❑ Incontinence or Bed Wetting
- ❑ None in this category

Women Only:
- ❑ Painful or Irregular periods
- ❑ Are you pregnant now?
  - ❑ No
  - ❑ Yes

Due Date:_____

Previous Pregnancies

_____

Infertility

Consent for Chiropractic Services

Patient Name: _____

D.O.B.: _____ Date: _____

By signing below, I authorize FBG Chiropractic and Wellness and Dr. Joe Palmer to complete a consultation and examination of myself. I understand that before FBG Chiropractic and Wellness begins any health care operations, I am required to read and sign this form stating that I understand the items below. I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examination and supportive therapies and procedures. If I decline to sign this form I accept and understand that Dr. Palmer reserves the right to refuse care.

By reading below, I have been made aware:

1. The process of delivering a 'Chiropractic Adjustment (manipulation)' may be performed manually, with a table mechanism, or with an instrument to the vertebra of the spine and/or associated structures (legs, arms, etc.) often resulting in an audible pop or click sound.
2. As an addition to the chiropractic adjustment, 'Supportive Therapies and/or Procedures' may be applied by the chiropractor, or by a staff member under the chiropractor's direction or supervision, incorporating the use of light, electricity, traction, motion, heat/cold therapy, or nutritional advice
3. That on occasion, some temporary soreness and/or stiffness may occur; less frequently aggravation of the presenting symptoms or initiation of new symptoms; rarely bruising, swelling; even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a chiropractic adjustment.
4. That Dr. Palmer has made no guarantee of a positive outcome from treatment.
5. I have been afforded ample opportunity for questions and answers.

Therefore, by signing below:

I consent to the performance of diagnostic and therapeutic procedures performed by Dr. Palmer and or his staff member under the direction and supervision of Dr. Palmer.

I consent to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by Dr. Palmer and/or staff, under the direction of Dr. Palmer.

Patient Signature: _____

Practice & Payment Policies

Patient Name: _____

DOB: _____ Today's Date: _____

1. **INSURANCE**: We are participating providers with Medicare only. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment from your insurer, we will refund/credit any overpayment to you.

- Medicare does not cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. All procedures billed in this office are considered covered unless limited by your specific insurance policy.
- We are NOT in network with other insurance companies and do not accept payments from them. If you are insured by a plan with which we have no prior arrangement, we will prepare your Superbill for you to submit to your insurance. This means the insurer will send any applicable reimbursement directly to you, and therefore, our charges for you are due at the time of service. Every insurance is different and will not necessarily reimburse you for the total charge of the appointment. Please contact your provider for details on their covered service
- By signing this document, you are stating that you understand and accept that you are financially responsible to Dr. Joseph Palmer, D.C. / FBG Chiropractic and Wellness for charges not covered by the assignment of insurance benefits.

2. **PAYMENT** is expected at the time of each visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, or non-covered charges from your insurance company. We will need to make a copy of a valid ID card or license during your first visit, as well as your insurance card.

Your account must be in good standing to receive treatments. Any balance due must be paid prior to services and treatments being rendered. Late charges of 12% annually will be applied to all patient balances 90 days old or greater.

3. **RETURNED CHECKS** will incur a $30 service charge. You will be asked to bring cash, certified funds, or a money order to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $30 service fee and collections action.

4. **COLLECTION FEES** By signing this form you state your understanding and agreement that in the event your account is placed in collections status, any additional fees incurred will be added to your outstanding balance. This includes but is not limited to late fees, collection agency fees, court costs, interest and fines. You understand the additional fees ill be your personal responsibility to pay in full.

5. **CANCELLATIONS OR MISSED APPOINTMENTS** If you are unable to make your appointment, please call the office to reschedule as soon as possible. Missed appointments or cancellations made within 24 hours of your appointment will be subject to a $25 cancellation fee, due before your next treatment. _____ **(initial here)**

6. **TARDINESS**: Please be on time for your appointments. Patients who have arrived late may be seen

after patients who have arrived for the appointment on time. New patients that are more than 15 minutes late to their scheduled time will be rescheduled.

7. **RELEASE OF PERSONAL INFORMATION** I hereby authorize thee and direct Dr. Joseph Palmer

D.C./ FBG Chiropractic and Wellness to release to governmental agencies, insurance carriers, or other healthcare facilities and associates who are financially liable for such professional and medical care, all the information needed to substantiate claim and payment

We are very concerned with protecting your personal health information. By signing below, you have authorized this office to contact you for office related health matters. Messages may be left on an answering machine/voicemail, or with the person answering your phone. Your cell phone number may be used for text (SMS) messages with upcoming appointment reminders. Emails may be sent to you regarding your current health and wellness program, billing reminders or office updates and marketing. Mailings from the office will be sent to the address on file and may include billing statements and marketing materials.

8. **PARENTS/GUARDIANS OF MINOR PATIENTS** By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent/guardian who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

9. **MOTOR VEHICLE ACCIDENTS:** In the event that you have been in a motor vehicle accident, you can use your PIP, or we can refer you to an attorney. We do not bill out to third-party insurance

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The office will supply you with a copy of this office privacy policies and procedures upon your request. This document outlines the use and limitation of the disclosure of your personal health information and your rights as a patient. By signing below, you give acknowledgement that you have been offered a copy of this document. FBG Chiropractic and Wellness.reserves the right to make changes to the practice and payment policies at any time.

By signing below, I understand and agree with the policies and procedures outlined in this form. I acknowledge and certify that all the information given to the office and provider in the Patient Intake Forms are true and accurate to the best of my knowledge. Any changes to my personal information or insurance or contact information will be given to the office in writing as soon as possible.

Patient Signature: _____ Date: _____