AMERICAN CHIROPRACTIC & INJURY CENTER
4406 SOUTH FLORIDA AVE STE 25, LAKELAND, FL 33813
Phone (863) 701-0109 Fax (863) 701-0309

Patient Registration Form

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip _____

Phone: _____ Cell: _____ Work: _____

D.O.B: _____ SSN: _____ SEX: M / F Martial Status: S, M, D, W

Email: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Major Complaint: _____

How long have you had this condition? _____

Car Accident: Y / N Work Comp: Y / N Date of Accident: _____

Insurance Information

Insurance: _____ ID/Claim # _____

Insurer: _____ D.O.B. _____

Adjuster: _____ Phone: _____

Attorney Information

Attorney: _____ Phone: _____

Address: _____ City/State: _____ Zip: _____

Patient Signature: _____ Date: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am responsible for any remaining balances. I also authorize American Chiropractic & Injury Center or insrance company to release any information required to process my claims.

____ Initial Exam ____ Re-eval ____ Final Exam Today's Date_____ D.O.L._____

Patient's Name: _____ D.O.B. _____

Current chief complaint, reason for visit: (description) _____

Past Medical History: Please circle if you **have ever had** any of the following:

High Blood Pressure	Cardiac Pacemaker	Heart / Liver Disease
Diabetes Mellitus	Metal Implants	Chicken Pox
Rheumatoid Arthritis	Lung/Tuberculosis	Mumps / Measles
Vascular Disease	HIV / Herpes	Gunshot Wound

List current/past **Medications** taken:

List any **Allergies**:

List any **Surgeries**:

Hospitalizations:

Social History: Tobacco: _____ Alcohol: _____ Exercise: _____

Marital Status: _____ Have Children? ☐ yes ☐ no Ages? _____

What type work do you do? _____

Have you traveled outside the country in the last year? _____

Family History: ___Asthma ___Cancer ___High Blood Pressure ___Heart Disease ___Diabetes

___Cardiac ___Lung ___Migraine Other: _____

Female History: **Any possibility** you may be pregnant? ☐ yes ☐ no

Prior motor vehicle accident? ☐ yes ☐ no If yes, how many? _____ When? _____

Were you injured? ☐ yes ☐ no Describe: _____

Other personal injury/accident? ☐ yes ☐ no If yes, describe: _____

Doctor: _____ Date: _____

4406 S. Florida Avenue, Suite 25
Lakeland, FL 33813
Ph: (863) 701-0109

CLINIC POLICIES

GENERAL POLICY

Welcome to American Chiropractic. It is our mission to provide you with quality Chiropractic care in a clean, friendly, and professional setting. Because we know that your time is very important to you, we make all efforts to run on schedule. In the event that you cannot make your scheduled appointment with the doctor or massage therapist, we kindly ask that you provide us with a 24 hour notice. There is a **$15.00 charge** for missing an appointment without a 24 hour notice.

FINANCIAL POLICY

American Chiropractic utilizes a pre-certification process to verify primary insurance coverage for your Chiropractic care. Coverage information is obtained from your insurance company using information provided by you, the patient/insured, at the time of the initial visit. We use this information to determine your financial responsibility for services provided to you at this facility.

The information provided by your insurance company is not a guarantee of payment, only an estimate of what might be covered under your policy. Final determination of benefits available under your insurance policy is determined when the claim is presented to your insurance company and we receive an explanation of benefits from them. We will send all necessary primary insurance claim forms, for you, to your insurance company for services you receive at this facility. We will send all documentation, as required by your insurance company, to ensure that your claims are processed in a timely manner.

Although we strive to be as accurate as possible in this process, we cannot and will not be responsible for any errors, omissions or false information provided to us by your insurance company. It is your responsibility, as the patient/insured, to be aware of and comply with all of t he restrictions for services provided in your policy.

After all co-pays, contracted plan reductions and insurance payment credits are applied to your account, any remaining portion will be the patient's/insured's responsibility. In the event that a particular service provided at this facility is found to not be covered service, then that particular service will be the patient's/insured's responsibility. Self-pay patients will be expected to pay for services received at this facility at the time of service. We take cash, checks, and all major credit cards. By signing below you acknowledge, and agree to, the above policies of American Chiropractic.

PRIVACY POLICY

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read and understand them or that I declined the opportunity to read them. I understand that this form will be placed in my file and maintained for six (6) years.

I hereby acknowledge that I have read and agree to the above policies.

Print Name _____ Date _____

Signature of patient, parent or legal guardian _____

American Chiropractic

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Fax: (863)701-0309

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO: _____

_____

_____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE THE FOLLOWING RECORDS TO:

American Chiropractic

4406 S. Florida Avenue Suite 25
Lakeland, FL 33813
Phone: (863)701-0109
Fax: (863)701-0309

- ALL INITIAL REPORTS, FOLLOW-UP REPORTS, DAILY SOAP NOTES, ETC.
- COPIES OF X-RAYS, MRI, BONE SCANS, CT FILMS, etc, WITH REPORTS
- REPORTS OF ALL DIAGNOSTIC TESTS, DO NOT SEND FILMS, FAX IF POSSIBLE
- PLEASE FAX RADIOLOGY REPORTS TODAY AND SEND FILMS BY MAIL ASAP
- ONLY RECORDS FROM THE PERIOD OF _____TO_____.
- OTHER_____.

NAME:_____ D.O.B._____

SOCIAL SECURTIY #:_____ CLINIC#:_____

PATIENT SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below I authorize being contacted for practice reminders by:
Mail _____;
Email_____; at email address
_____;
Telephone numbers_____;
_____;
By voice mail _____;
By text message _____;
By FaceBook address _____.

By checking this checking the lines below I authorize being contacted for birthday greetings or promotions about the practice by:
Mail _____;
Email _____ at email address
_____;
Telephone numbers_____;
_____;
By voice mail _____;
By text message _____;
By FaceBook address _____.

By checking this checking the lines below I authorize the doctor to personally discuss with me products that may benefit my health or condition. _____

_____ _____
Patient Name (please print) Date

_____
Name of Parent, Guardian or Patient's legal representative

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____	_____
_____	_____
_____	_____