



# 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 # ? H W C  
 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 or 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 may 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 your 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.

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Signature of Patient, Policy Holder or Legal Guardian

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Date

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Printed Name