TCC LLC

Patient #_____
CP _____
X-rays CTL _____

Confidential New Patient Information Form

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. PLEASE PRINT.

Today's Date:_____

Name:

Last _____ First _____ MI _____

Email Address: _____

Mailing Address: _____ City:_____

State:_____ Zip Code:_____

Phone# (H) _____ (C)_____(W)_____

Date of Birth:____/_____/_____Age:_____ Sex: (circle one) Male/Female SS#:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Are you currently pregnant? Yes/No Number of Children:_____

Occupation:_____ Employer:_____

Employer Address: _____

Do you have insurance through work? Yes/No

Spouse's Occupation:_____ Spouse's Employer: _____

How did you hear about our practice?_____

Chief Complaint:_____

Have you ever been seen by a Chiropractor? Yes/No If yes when was your last visit?_____

Emergency Contact:
Name:_____ Relation:_____

Phone:_____

*I agree to pay for services rendered for the above-mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I personally am responsible for payment of any an all services rendered or non-covered. I also understand that if I suspend or terminate my care and treatment my fees for professional services rendered to me will be immediately due and payable.

Patient or Guardian Signature:_____Date:_____/_____/_____

Accident Information:

Is this visit due to an accident? Yes ☐ No ☐ if yes, what type? Auto ☐ Work ☐ Other ☐

Date of Accident:_____/_____/_____

TCC
LLC

CONSENT TO EXAMINE AND TREAT

The undersigned consents to any examination (x-ray or otherwise) including, but not limited to, physical, orthopedic, and neurological evaluation, visual inspection, palpation, exercise stress test, electromyography (EMG) and electrocardiograph (EKG) and photography.

The undersigned also consents to observation of the therapeutic or diagnosed procedures by staff personnel or medical personnel in training as permitted by the attending practitioner and allowed by clinic policy. Treatment procedures that may be used in your treatment include, but are not limited to, manipulative therapy, joint mobilization, myofacial release, trigger-point therapy, ultrasound, diathermy, electrical therapy, traction, muscle stretching, hydrocollator therapy, cryo-therapy, nutritional supplementation, rehabilitative exercise, and massage.

Cases will be managed with all due concern and with the evaluation of response to previous care provided. Home care instructions will be given as appropriate to enhance your treatment program. Compliance with the recommendations for home care and follow-up care is necessary for the resolution of your complaint.

Because of modern techniques and equipment, examination and therapeutic procedures carry with them a low risk of complication. Even though problems seldom arise during these procedures, risks must be recognized and considered. Any procedure intended to help may also do harm. While examination and therapeutic procedures used in this clinic are considered remarkably safe and effective, understand that occasionally there may be adverse reactions that occur. Although the chances of experiencing any of these complications are extremely small, it is the practice of this office to fully inform and educate our patients, Complications reported in the literature included but are not limited to pain, swelling, bruising, discoloration, inflammation, disc injury, sensory changes, bleeding, fracture, fainting, irregular heartbeat, heart attack, spinal cord damage, nausea, burns, soft tissue injury, stroke dizziness, or weakness. All patients respond differently to the treatment procedures. Each case must be evaluated separately.

If you do not fully understand the above or have questions about anything mentioned in this document, please do not sign it until these matters have been resolved with further discussion.

I have read the above explanation of treatment and diagnostic procedures used in this clinic and have myself decided that it is my best interest to submit to these procedures.

Printed Name:_____

Signature:_____ Date:_____

Witness:_____

INDIVIDUAL CONSIDERATION

By virtue of my signature set forth below, I hereby request that my doctor and institutional provider reduce their usual and customary charges in order to allow me to receive care required by my current health care condition.

I represent and warrant that my financial status is such that I would be unable to receive diagnostic and treatment services if usual and customary charges were applied to the services required by my condition.

I recognize and acknowledge that this Agreement to reduce usual and customary charges is undertaken for my benefit, that this is dependent on my financial status as of the date of this Agreement, that it will result in a fee arrangement from the one usually in place for the services in question and that the arrangement entered into by the parties for the sole and exclusive benefit.

In light of foregoing, I hereby agree to the following:

1. I will not seek reimbursement for the services rendered to me under this arrangement from any insurance company, employer, welfare program, government entitlement program (Medicare or Medicaid), Workers' Compensation program or other third-party payor.
2. If any third-party payor responsible for all or part of the payment due as a result of services rendered under this Agreement contacts me, I will notify such payor of this arrangement and the reduced fees achieved as a result of the Agreement.
3. If the financial circumstances which cause me to qualify for the financial hardship under this agreement change, I will immediately notify my doctor and institutional provider in order to allow them to determine whether my financial status will then allow me to pay usual and customary charges for the services which I receive from the date forward.

We will give you an individual consideration of $_____.

Patient Name:_____

Patient Signature:_____

Date Signed:_____

Witness Signature:_____

Date Signed:_____

CONSENT TO TREAT A MINOR

(Under the age of 18 years old)

Patient's Name:_____

Date of Birth:_____/_____/_____

Age:_____

Parent/Guardian Name(s):

_____

I, [print name], _____, the undersigned, being the parent and/or legal guardian of the above-referenced minor consent to and request that she/he be examined, evaluated and treated at this office within the scope of any duly licensed Doctor of Chiropractic (D.C.). Services rendered may include but are not limited to, applicable x-rays, examinations, evaluations, diagnoses, and treatment as indicates and/or recommended by and under the supervision of any licensed Doctor of Chiropractic or other qualified staff of The Chiropractic Center, LLC.

This consent shall be valid from this date forward until this applicable medical case is resolved or withdrawn by the undersigned. If I withdraw this consent, I, the undersigned, understand that I am responsible for, and agree to pay any and all outstanding monies due for services rendered hereunder and understand that I must notify The Chiropractic Center LLC. IN WRITING of my intent to withdraw consent.

SIGNED [today's date]:_____

By: PARENT:_____

PRINT NAME:_____