Balanced Living Chiropractic
REGISTRATION FORM

INTAKE DATE:_____ REFERRED BY:_____

PATIENT NAME:_____ Date of Birth:_____ Age:_____
ADDRESS:_____
CITY:_____ STATE:_____ ZIP:_____
SS#_____ EMPLOYER:_____
PHONE:_____ CELL:_____ WORK:_____
SEX: FEMALE MALE MARITIAL STATUS: Single Married Divorced
RESPONSIBLE PARTY (If patient is a minor):_____ Date of Birth:_____
ADDRESS:_____ SS#_____
CITY:_____ STATE:_____ ZIP CODE:_____
PHONE#:_____ CELL#:_____ WORK#:_____
INSURANCE #1:_____
POLICY#:_____ GROUP#:_____
POLICY HOLDER:_____ PHONE#:_____
INSURED DOB:_____ EMPLOYER:_____
INSURANCE #2:_____
POLICY#:_____ GROUP#:_____
POLICY HOLDER:_____ PHONE#:_____
INSURED DOB:_____ EMPLOYER:_____

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD FOR PHOTOCOPY)

In order to submit a claim for payment to us for services covered under your policy, I must have authorization to release medical information to your insurance company and to my billing company for paper and electronic billing. I authorize the release of any medical information necessary to process my medical service claims. I permit a copy of this authorization to be used in place of the original. I hereby authorize Balanced Living Chiropractic and its billing company to file for benefits on my behalf for Chiropractic services received. Insurance payments shall be made directly to Balanced Living Chiropractic. If I have Medicare insurance, I authorize Balanced Living Chiropractic to release to the Social Security and Care Financing Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I certify that I am financially responsible for all services not paid by insurance. This authorization is valid indefinitely until revoked by myself or by Balanced Living Chiropractic by written request. I consent to Balanced Living Chiropractic to provide professional services to me.

SIGNATURE_____ DATE:_____

BALANCED LIVING CHIROPRACTIC
4702 JAMES SAVAGE RD
MIDLAND MI 48642

Chiropractic Case History

Name_____ Sex M F Date_____
Address_____ City_____ State__ Zip_____
Home Phone_____ Alt. Phone_____ Date of Birth_____ Age___
Referred by_____ Social Security No._____
Occupation_____ Employer_____
Have you ever received Chiropractic Care? Y N If yes, when?_____

1. Primary reasons for seeking chiropractic care:

Primary reason:_____
Other reasons:_____

2. Chief Complaint:

Location of Complaint:_____
Initial cause of this complaint:_____
When did this complaint begin?_____
Are you presently under a doctor's care for this complaint? Y N Dr's. Name_____
Please circle the type of complaint/pain: Dull/Aching/Sharp/Shooting/Burning/Throbbing/Deep/Other_____
Does this complaint/pain radiate or travel (shoot) to other areas of your body? Y N Where?_____
Do you have numbness or tingling in your body? Y N If yes, where?_____
Grade Intensity/Severity: 0 1 2 3 4 5 6 7 8 9 10 (0 = No Pain 10 = Worst Pain Possible)
How frequent is complain present? How long does it last?_____
Does anything aggravate the complaint/pain?_____
Does anything make the complaint/pain better?_____
Does this complaint/pain interfere with: work, home life activities or sleep?_____

3. Previous Interventions: treatments, medications, surgery or care you've sought for your complaint/pain:

_____

_____

4. Past Health History:

Previous illnesses you've had in your life:_____
Previous injury or trauma:_____
Have you ever broken any bones? Which ones?_____
Allergies_____
Medications_____
Surgeries and dates_____
Pregnancies & date of delivery_____
On a scale of 1-10, how committed are you to resolving this complaint/pain?_____
Are there any other health concerns you would like to address?_____

_____

Balanced Living Chiropractic
4702 James Savage Rd
Midland MI 48642
Phone: 989.495.9003 ~ Fax: 989.495-0025

Authorization to pay Balanced Living Chiropractic

I hereby allow my insurance company to pay Balanced Living Chiropractic directly. The check is to be made out to Balanced Living Chiropractic and mailed to this clinic. I understand that all professional and medical expenses will be billed directly to my insurance company. I understand that if my insurance company does not pay Balanced Living Chiropractic I will be financially responsible for the full or partial outstanding balance. I am authorizing the release of any information concerning my health condition to my insurance company, auto insurance carrier, or claim adjustor in order to process claims for reimbursement of charges. The authorization for assignment will be in continual effect until revoked by both parties.

_____ _____

Patient/Insured Signature **Date**

_____

I agree to be financially responsible for my insurance co-pays, deductibles and any services rejected by my insurance company.

_____ _____

Patient Signature Date

Records Release

To_____, I hereby authorize you to release to Balanced Living Chiropractic any information including diagnosis, treatment records and X-rays of my case.

_____ _____

Patient Signature Date

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I acknowledge that Balanced Living Chiropractic, PLLC's "Notice of Privacy Practices" has been provided to me.

I understand I have the right to review Balanced Living Chiropractic PLLC's Notice of Privacy Practices prior to signing this document. Balanced Living Chiropractic, PLLC's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosure of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Balanced Living Chiropractic, PLLC. The Notice of Privacy Practices for Balanced Living Chiropractic, PLLC is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Balanced Living Chiropractic PLLC's duties with respect to my protected health information.

Balanced Living Chiropractic, PLLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative Authority

BALANCED LIVING CHIROPRACTIC

Our patient software requires additional information on all of our patients. Please complete the following confidential questions. We appreciate your cooperation.

Name:_____ Date:_____

1. Prescription medication taken:

_____Dose____Qty____Frequency_____Reason_____Refills_____

_____Dose____Qty____Frequency_____Reason_____Refills_____

_____Dose____Qty____Frequency_____Reason_____Refills_____

_____Dose____Qty____Frequency_____Reason_____Refills_____

_____Dose____Qty____Frequency_____Reason_____Refills_____

2. Allergies to medications and reactions:

_____

_____

_____

3. Demographics:

Gender: _____Male _____Female Date of Birth_____

Preferred language:_____

Ethnicity: _____Hispanic _____Non-Hispanic

Race: _____White _____Black _____Asian

4. Smoking Status:

_____Current every day smoker _____Current some day smoker

_____Former smoker _____Never smoker

E-mail address:_____

For office use only:

Pt. Educ. Date:_____
Vitals: Ht:_____ Wt:_____ BP_____
Timely Access Date:_____
Clinical Summary Record:_____

Pt Reminders:_____ BALANCED LIVING CHIROPRACTIC

Terms of Acceptance

When a person enters this office for care, it is essential that we are both working towards the same objectives. Chiropractic only has one objective. It is important for us to establish a clear understanding of the philosophy and procedures of this office so that there is no confusion.

Heath: A state of optimal physical, social and mental well-being, and not just merely the absence of disease or other symptoms. Without interference, the nervous system is able to coordinate all of the body's systems and functions.

Adjustment: A specific force applied to the body in order to allow the body to heal itself. The purpose of the chiropractor is to remove the irritation to the nervous system and unlock the healing potential of the body.

Vertebral Subluxation: Accidents and injuries create a weakness in the body that allows the spine to lock in a stressed position. This stressed position leads to imbalances in the spine showing up as postural distortion, and leads to nervous imbalance.

Subluxated Spine: Once the spine moves into a stressed position the entire spine is affected, showing spinal distortions and creating pressure on the spinal cord. This interference can lead to abnormal function anywhere in the body.

Diagnosing and treating disease (or its symptoms) is the practice of medicine. Chiropractic is not medicine and does not diagnose or treat disease. At Balanced Living Chiropractic, we are concerned with adding health to the body, not treating the lack of it. Whatever stage of health you are in, you can benefit from a properly functioning nervous system. If during you care we find something out of the ordinary, we will notify you. If it is not Chiropractic in nature it will be your responsibility to seek care with the appropriate professional.

Our objective is to balance your spine, thus removing nervous system interference and allowing the body to heal itself and function at 100% of its potential.

"I understand the above statement and choose to accept care under these terms"

_____ _____

Signature (legal guardian if under 18) Date

_____

Printed Name (or name of Minor)