



## Welcome to our Family Chiropractic Office

Thank you for choosing our office for chiropractic care. We are committed to providing your family with the highest quality of corrective and wellness chiropractic care available so that you and your family can enjoy an active, healthy, life. We will be working together to help you and your family reach your health and wellness goals.

If you ever have any questions about your chiropractic care, please don't hesitate to ask one of our highly educated chiropractic team members. All of your questions, even the ones you haven't even thought of yet, will be answered during your Chiropractic Report.

# Complete Care Chiropractic Wellness Center

420 Folsom Rd, Ste B, Roseville, CA 95678 (916)749-1346

## Personal and Family Health History

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_  
 E-mail \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender M / F  
 Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_  
 Social Security # \_\_\_\_\_

Date \_\_\_\_\_  
 Referred By \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Marital Status    S        M        D        W  
 Spouse's Name \_\_\_\_\_  
 Person responsible for payment \_\_\_\_\_  
 Insurance Contribution     Yes     N

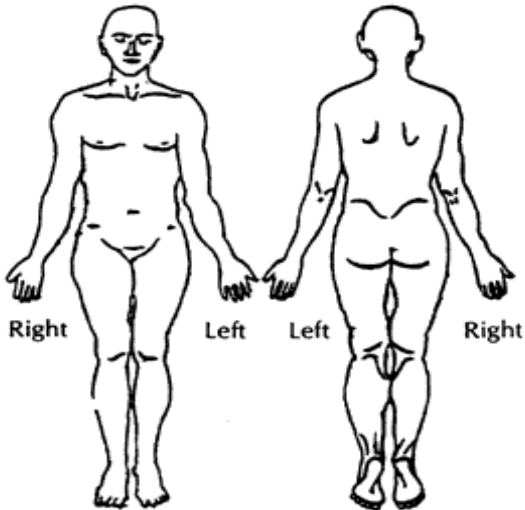
### Number of Children and Ages

### Previous Chiropractic Care?

Name _____	Age _____	Yes _____	No _____	Reason _____
Name _____	Age _____	Yes _____	No _____	Reason _____
Name _____	Age _____	Yes _____	No _____	Reason _____
Name _____	Age _____	Yes _____	No _____	Reason _____

### Current Health Condition

Present Complaint, Reason for Your Visit Today? \_\_\_\_\_  
 When did you first notice it? \_\_\_\_\_  
 How did it happen? \_\_\_\_\_  
 Pains are     Sharp     Dull     Achy     Throbbing     Other \_\_\_\_\_     Constant     Intermittent  
 Rate your pain 1-10, with 10 being the worst pain you can imagine. Today's pain \_\_\_\_\_ Pain at best \_\_\_\_\_ at Worst \_\_\_\_\_  
 What aggravates your condition/pain? \_\_\_\_\_  
 What relieves your condition/pain? \_\_\_\_\_  
 Is condition worse during certain times of the day? \_\_\_\_\_  
 Is this condition interfering with work? \_\_\_\_\_ Sleep? \_\_\_\_\_ Routine? \_\_\_\_\_ Other? \_\_\_\_\_  
 Is this condition getting  better  worse or  no change? Other Doctors seen for this condition? \_\_\_\_\_  
 Any home remedies? \_\_\_\_\_  
 Are you now, or is there any possibility you might be pregnant     Yes     No



**Please shade in the areas of complaint on left and mark it as follows:**

- P: Pain**
- N: Numbness**
- S: Stiffness**
- SP: Shooting Pain**
- W: Weakness**

### Accident History

Job     Auto     Other 1) \_\_\_\_\_ Date: \_\_\_\_\_  
 Job     Auto     Other 2) \_\_\_\_\_ Date: \_\_\_\_\_  
 Job     Auto     Other 3) \_\_\_\_\_ Date: \_\_\_\_\_

Are you currently under the care of another Doctor or health care professional? \_\_\_\_\_ For What? \_\_\_\_\_  
 Any over the counter/prescription drugs you take? \_\_\_\_\_  
 Have You Had Surgery? \_\_\_\_\_ For What? \_\_\_\_\_ When? \_\_\_\_\_  
 Side effects from drugs or surgery? \_\_\_\_\_



## Office Fee Schedule and Financial Policy

<u>Service</u>	<u>Fees</u>
Consultation	No charge
Initial Visit	\$55 (Evaluation, Adjustment and Chiropractic Report)
Adjustment	\$30-45
Wellness Adjustment Plans	\$63 - \$79 / month
Family Wellness Adjustment Plans	\$125 - 158 / month

Dr. Atkinson would like to know if you have any financial hardships that make it difficult for you to complete your treatment plan. Please feel free to discuss this matter with him and we will do all that we can to accommodate you.

### Financial Policy and Chiropractic Active Life Plans

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless you arrange a Chiropractic Active Life Plan in advance. These plans are designed to be the most cost effective way to keep you and your family as healthy as possible. They include Corrective Adjustment Plans (CAP) and Wellness Adjustment Plans (WAP). Details of these plans will be discussed with you during your chiropractic report.

I, (name) \_\_\_\_\_ have read and I understand the above policies.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

# Insurance Policy

**Health Insurance:** We are willing to work with almost all companies that will contribute to your chiropractic care. If you have insurance that covers chiropractic, full payment of services is expected until we verify your specific coverage. Once verified any payment credits you may have will be counted toward your future care. Your specific coverage may take up to 72 hours for verification. We will be happy to offer any assistance in this matter. Please remember, there are many different plans with many different levels of deductibles, Co-payments, Co-insurance and coverage restrictions.

Please list any and all insurance and/or employee health care plan coverage you or your spouse may have  
Insurance Company or Health Care Plan Name \_\_\_\_\_

ID#: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

Name of Subscriber \_\_\_\_\_

Employer of Subscriber: \_\_\_\_\_

Patients Relationship to Subscriber  Self  Spouse  Child  Other

Birthday of subscriber \_\_\_\_\_

## LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Complete Care Chiropractic/Dr. Adam Atkinson for insurance reimbursement, if any, otherwise payable to me for services rendered from such Doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

I have read and I understand the above insurance policy.

\_\_\_\_\_  
Signature of Insured / Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**Complete Care Chiropractic  
Informed Consent to Chiropractic Treatment**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Adam Atkinson and/or other licensed doctors of chiropractic who now or in the future work at Complete Care Chiropractic or any other office or clinic.

I have had an opportunity to discuss with Dr. Adam Atkinson and/or with other office or clinic personnel about the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also discussed or had an opportunity to discuss its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature (or parent/guardian) \_\_\_\_\_ Date \_\_\_\_\_

Patient Name (Print) \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_