CityLimits Chiropractic

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INFORMATION/APPLICATION FOR CARE

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 _____________________________________ Home Phone _______________ Work Phone ______________

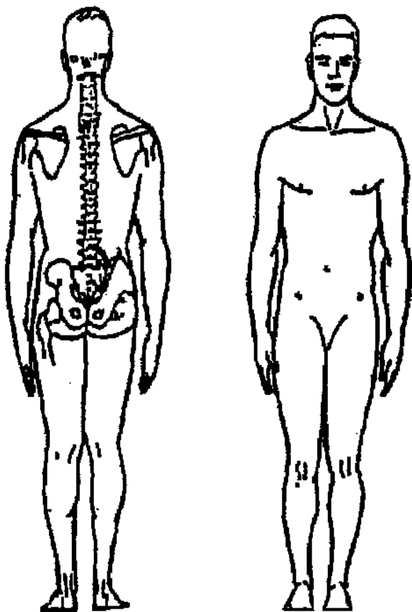
Cell Phone _______________________ E-Mail Address ____

Address ___________________________________ City ____________________ State ________ Zip ___________

Age _____ Birth date ________________________

Emergency Contact ______________________________________ Emergency Contact # ________________

Whom May We Thank For Referring You? ____________________



COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example; dull, sharp, consistent, off & on, when standing, when sitting, etc…

MAJOR COMPLAINTS

(Please list any condition you are being treated for or are experiencing.)

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- **What is your occupation?** _________________________
- How long have you been experiencing these issues? ________________________
- Have you received care for this issue in the past? If so, what kind? ___________________________
- How did these conditions first start? ____
- Are these issues **A**. Getting Worse **B**. Getting better **C**. Staying the same? ___
- What makes these issues: Worse? ____

  Better? ____
- Are you currently taking any medications? If so, which ones? ____

CONSENT FOR TREATMENT AND
AUTHORIZATION TO PERFORM X-RAYS

Terms of Acceptance

If I become informed by Dr. Davis that diagnostic x-rays are advisable in my case so that a complete analysis can be made of my present musculoskeletal problem (or illness), I authorize City Limits Chiropractic to perform such radiographic examination necessary to diagnose, and to administer whatever treatment is deemed necessary to treat my present problem (or illness).

To the best of my knowledge, I am NOT pregnant and the above-named Doctor has my permission to x-ray me for diagnostic interpretation.

Signed: ______________________________ Date ________________________

A superbill will be provided upon request for you to submit to your insurance company for reimbursement directly to you. This method is used to help keep health care costs low.

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Signed: ____

Policies for Patients

☐ **APPOINTMENT SCHEDULING/MISSED APPOINTMENTS**

A personal appointment calendar will be created for you. If an appointment must be missed, please call our office BEFORE your scheduled time to re-schedule. If you are going to be either 10 minutes EARLY or LATE to an appointment please call the office so that we may adjust or reschedule accordingly. In addition, if you *are* 10 minutes early or late you will be asked to wait until your appointment time or the next availability.

☐ **FINANCIAL AGREEMENTS**

We expect that the financial arrangements made at the beginning of your care will be honored and kept. If making in house payments, we require each patient to provide a credit card on file with us, or post dated checks for payments to be made. If making cash payments, credit card on file will not be charged if payment is made by their due date. If at any time there is a concern over your regularly scheduled payment, please notify our office immediately so that a consultation can be scheduled with the doctor to revisit financial matters, at which any discounts, may be reduced. If you have insurance, you may request statements at any time from the front desk to submit for reimbursement.

☐ **INTERRUPTION OF CARE**

In the unlikely event it is necessary to discontinue your care, any outstanding fees become payable and due immediately. If any interruption or care is discontinued, please let our office know as soon as possible.

☐ **WHAT IS NOT INCLUDED**

- Any guarantee that we can prevent or cure any illness, injury, or disease.
- Care for, or related to, auto accidents, work injuries, or personal injuries where there is a third party liable or pending litigation. In this event, your current agreement will be suspended until the case is resolved or settled.
- Any medical equipment or supplies, nutritional supplements, pillows, or any special outside service fees such as lab fees or radiology review by outside consultants, ect.
- Although the risk is very low, City Limits Chiropractic Inc. is not liable for injury or bodily harm associated with care.

I have read and understand the above policies and agree to abide by them.

Signed: ____