Quinn Chiropractic Center

Welcome to our Practice

Today's date _____ Birth Date _____ Age _____

Name _____ Sex: □ Male □ Female Number of children _____

Address _____ Marital Status: □ Single □ Married □ Divorced □ Widowed

City/State/Zip _____ Occupation _____

Phone (home) _____ Employer _____

Phone (work) _____ Do you have insurance? □ Yes □ No □ Will have soon

Phone (cell) _____ Social Security Number _____

E-mail _____ Drivers License # _____

Please check how you heard about our office:

□ Referral _____ □ Website / Internet □ Walk-In / Drive-By □ Yellow Pages

Was this injury caused by: □ Auto accident □ On-the-job injury □ Other _____

Describe:

_____

_____

Have you been treated for this condition? □ Yes □ No

If yes, when? _____ For how long? _____

By whom? _____ Results? _____

Are you currently being treated by any other Doctor(s)? □ Yes □ No

If yes, whom? _____ Why? _____

Are you currently taking any over-the-counter or prescription medication? □ Yes □ No If yes, what and why?

_____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome

Describe your current problem and how it began:

_____

_____

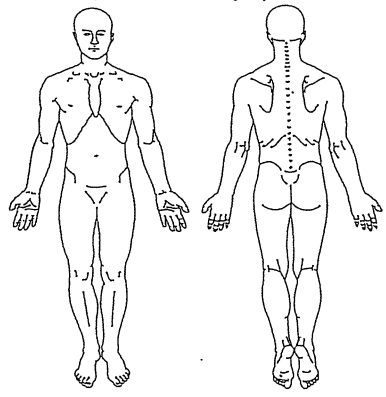
Date problem began: _____

Current Complaint (How you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

Mark an "X" on the picture where you have pain or other symptoms



How often are your symptoms present? (Please circle response) 0-25% 26-50% 51-75% 76-100%

Can you perform your daily activities? Yes No (Describe) _____

_____

Have you had spinal X-RAYS, MRI, CT SCAN? No Yes Date(s)/Area(s) taken: _____

Please check any of the following that apply to you:

□Arthritis □Allergies □Asthma □Blood Pressure, high/low □Blood Clots

□Cancer □Corticosteroid use □Depression □Diabetes □Disc Problems

□Diverticulitis □Alcohol/Drug Dependence □Eating Disorder □Epilepsy □Fibromyalgia

□Gallbladder Disease □Gout □Headache □Hearing problems □Heart Disease

□Hepatitis □HIV positive/ AIDS □Insomnia □IBS □Kidney/Bladder Disease

□Liver Disease □Lung Disease □Mental Illness □Obesity □Osteoporosis

□Sinus Problems □Skin Problems □Stroke □Thyroid Trouble □Ulcer

□Urinary problems/UTI □Varicose Veins □Vision Problems □Water retention

□Cancer/Tumor(explain)_____ □Currently Pregnant, # Weeks_____

Family History (circle if applicable): Cancer Diabetes High Blood Pressure Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate to the best of my knowledge. I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health conditions or health plan coverage in the future.

Patient Signature: _____ **Date:** _____

FINANCIAL OFFICE POLICY FOR QUINN CHIROPRACTIC CENTER
Office of Dr. John R. Quinn, D.C.

We welcome you to our office. Your health is our chief concern and we strive for excellence in chiropractic care. In order to make the handling of your financial obligations as smooth as possible, please read and sign the following office policy. If you have any questions, our staff will be happy to assist you.

GENERAL INSURANCE INFORMATION

Please remember that all health and accident policies are *arrangements between you and the company* that writes the policy. All charges in this office are your personal responsibility and all fees are charged directly to you. **Any co-payments are due at the time of services**. As a courtesy to you, we will prepare any necessary reports and insurance forms to assist in collections from your insurance company. We will also bill insurance on your behalf and will expect payment from them within sixty days. Should the claim remain unpaid over sixty days for any reason, we will then personally bill you for the balance, net 15 days. Please note that this office will not enter into a dispute with an insurance company over your claim. Because there are so many types of insurance plans, *it is the responsibility of the patient to be fully informed as to what is included or excluded in the policy*, as well as requirements or limitations. *We cannot assume this responsibility*. Should you have any questions about your coverage, please refer to your personnel department or insurance representative.

PERSONAL INJURY

If you have medical coverage (Medical Payment) on your auto policy, we will bill them directly for payment for your care. This coverage is in place to immediately handle your medical needs regardless of who is at fault. If you are not at fault, you will not be penalized by your insurance company. They will collect for reimbursement from the responsible party. We do not wait for payment on your bill. If you have retained an attorney in the case, we must have a signed lien in our office on file signed by both yourself and your attorney. Until we have such a lien in our file, you must pay cash for your visits.

MEDICARE

Medicare will be billed on your behalf. Keep in mind that **Medicare will not reimburse you for physiotherapy modalities done in our office, for the examination procedure conducted or X-rays**. Medicare reimburses for chiropractic manipulation of the spine only. All care is based on medical necessity. Medicare patients are required to sign an ABN 90 form to be kept on file.

PERSONAL PAY/CASH

Cash accounts are payable at the time of services unless previous arrangements were made.

MASSAGE POLICY

1. Due to the personal nature and close contact of massage therapy we ask massage patients to be aware of their personal hygiene.
2. There is a **$15.00 missed appointment fee** if a 24 hours notice of cancellation is not given. This fee is the responsibility of the patient.

PAST DUE BALANCES

Please note that all past due balances will incur a 1.5% monthly interest charge.

If you have any questions, please feel free to discuss them with the office staff.

I HEARBY AUTHORIZE PAYMENT OF ANY INSUANCE BENEFITS AVAILABLE FOR CHIROPRACTIC SERVICES TO DR. JOHN R. QUINN D.C./QUINN CHIROPRACTIC CENTER.

I HAVE READ AND UNDERSTAND MY RESPONSIBILITY TO PAY FOR MY CARE FOR SERVICES IN THIS OFFICE.

_____ _____

Print Patient Name Date

_____

Patient Signature

Signing below signifies that you have received a copy of our *Notice of Privacy Practices*

By way of my signature, I provide Quinn Chiropractic Center with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

I Acknowledge that I have received the *Notice of Privacy Practices* from Quinn Chiropractic Center

Patient Signature:_____

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures, including examination tests, diagnostic x-rays and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of Chiropractic named below and/or other licensed doctors of Chiropractic who now, or in the future, render treatment to me, while employed by, working for, or associated with, or serving as a backup for the doctor of Chiropractic named below.

I understand that, as with any health care procedures, there are certain complications which may arise during a Chiropractic adjustment. Those complications include, but are not limited to; fractures, disc injuries, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading to, or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, are in my best interests.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of Chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of the Chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to the treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

John R. Quinn, D.C.
207 S. Halcyon Rd.
Arroyo Grande, CA 93420
Phone: (805)481-9696

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

Printed Name of Patient	Date
Signature of Patient	Date
Signature of Patient Representative	Date
Witness to Patient's Signature	Date
Translated by	Date