Haymarket Chiropractic and Rehabilitation, PC
Virginia Sports Chiropractic of Warrenton, PC

Patient Information

_____

Date / Time (Office Use Only)

Name: _____ **Social Security** (For Insurance Purposes): _____

Street Address: _____ Phone: Home/Cell (____) _____

City, State, Zip: _____ Work Phone: (____) _____

Sex: ☐ Male ☐ Female Date of Birth: _____ / _____ / _____

Employer: _____ E Mail : _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower ☐ Life Partner

Spouse/Emergency Contact Name: _____ Contact Number: _____

Primary Care Physician or Referring Physician: _____

Practice: _____ Contact Number: _____

Appointment Reminders - Haymarket Chiropractic/Virginia Sports Chiropractic of Warrenton(VSC) provides appointment reminders by text or email. If you wish to receive appointment reminders please provide your email above.

INSURANCE INFORMATION:

Full Name of Primary Insurance Holder: _____

Date of Birth: _____ / _____ / _____

Relationship to patient: *Please circle one* → **Self** **Spouse** **Parent** **Other** _____

Guardian / Responsible Party Information (If Patient is a Minor)

Name _____ Date of Birth _____ SS # _____

Address: _____ ☐ Same As Patient

Relationship to Patient _____ Signature _____

How did you hear about us? (Be specific)

☐ Facebook ☐ Internet/Website ☐ Insurance Company ☐ Existing Patient ☐ Doctor/ Physician

☐ Other _____

Haymarket Chiropractic & Rehab
14535 John Marshall Highway, Suite 104
Gainesville, VA 20155
Phone 703-753-0974
Fax 703-753-9709

Email Haymarket Office: haymarketptc@gmail.com
Email Warrenton Office: vasportschiropractic@gmail.com
Website for both offices: www.haymarketchiropractic.com

Virginia Sports Chiropractic
331 Walker Dr, Ste 6
Warrenton, VA 20186
Phone 703-753-0974
Fax 703-753-9709

Additional Medical History/Information

Patient Name: _____ Today's Date: _____/_____/_____

Height: _____ Weight:_____

****Please write N/A for any sections that do not apply to you****

Medications (including supplements):

_____

_____

_____

Are you currently taking (please circle): Statins Antibiotics

Allergies: _____

_____

Fractures: (please include approx. date and location, including R/L if applicable)

_____

_____

Family History: (please include diagnosis and which family member is affected)

_____

_____

_____

Have you been diagnosed with (please circle): Cancer Diabetes Rheumatoid Arthritis

Have you had any surgeries: No Yes (please list) _____

_____

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Consent to Treat

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or plan of care for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By SIGNING below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician and/or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which is has brought me to seek care at this practice.

The welcome package / information package and all data from Haymarket Chiropractic and Rehabilitation / Virginia Sports Chiropractic of Warrenton (VSC) may be used for health, information, and billing purposes interchangeably between these different office locations if necessary.

☐ I have read the above statements and I understand the information provided. I therefore authorize this clinic to proceed with Chiropractic care and treatment. **(PLEASE INITIAL box to the left)**

Notice of Privacy Practices

I acknowledge by signing below that I have been given a copy of Haymarket Chiropractic / Virginia Sports Chiropractic of Warrenton (VSC) Notice of Privacy Practices. I understand that if I have any questions or complaints, I may contact the facility.

☐ I have read and understand the above statements. **(PLEASE INITIAL box to the left)**

Assignment of Benefits Authorization

I certify that I, and/or my dependent(s), have insurance coverage. I assign directly to Haymarket Chiropractic & Rehabilitation and / or Virginia Sports Chiropractic of Warrenton (VSC) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I also authorize release of medical information relevant to these services when required by Health Care Financing Administration (HCFA), its agents, or insurance carriers for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

☐ I have read and understand the above statements. **(PLEASE INITIAL box to the left)**

I have read and understand the above statements.

Printed Name of Patient	Printed Name of Guardian/ Responsible Party(If patient minor)	Date
Signature of Patient/Patient's Guardian	Relationship to Patient (if patient is minor)	Date

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Current Condition

Name _____ Today's Date: _____

Reason for Today's Visit: _____

When did Symptoms begin: _____

Mechanism of Injury: _____

What makes your symptoms WORSE: _____

What makes your symptoms BETTER: _____

What type of Pain? Circle all that apply

Sharp Dull Throbbing Ache Stiff Numb Shooting Burning

Any Radiation of Pain (Circle): Down legs? Down arms? Into head? _____

Rate your Discomfort / Pain: 0 (no pain) 10 (severe pain)

0 1 2 3 4 5 6 7 8 9 10

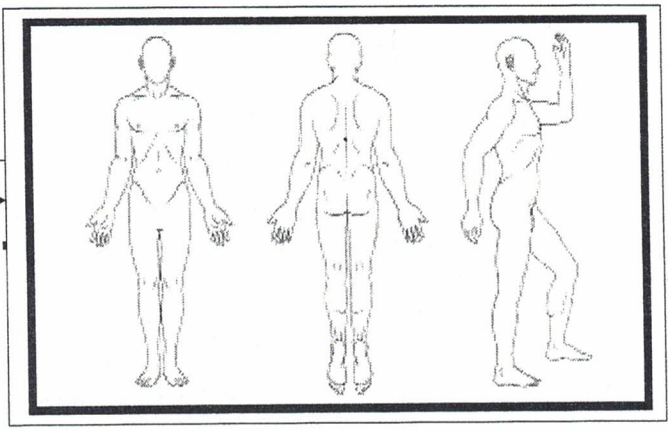
Are your symptoms worse in the: AM PM Overnight Movement dependent

Have you had any recent: x-rays MRI CT Labs

If so, Where? _____

Previous Episode Y / N, When? _____

*Please indicate in the picture box to the right where you are hurting. →



Doctor Only Below this line:

Physical

ROM: WNL _____

Muscle: WNL vs Abn: C5 C6 C7 C8 T1 L4 L5 S1 ToeWalk HeelWalk

Reflex: WNL vs Abn: Biceps(C5/6) Triceps (C6/7/8) BrachioR (C5/6) Knee(L2/3/4) Achill(S1/2)

Dermatomes: WNL vs Abn: C5 C6 C7 C8 T1 L4 L5 S1

Orthopedic Testing: WNL _____

Palpations: C0/1 C/S T/S L/S SI Extremity: L / R _____

Posture: Kyphotic, Slumped, Scoliosis, Anterior Head Carriage

Differential Diagnosis: Subluxation / Muscle Spasm / _____

Treatment Plan: _____ x per Week for _____ Weeks PRN

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Office and Payment Policies

1. **Insurance**: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. **If your insurance coverage changes, please notify us before your next visit** so we can make the appropriate changes to help you receive your maximum benefits. **You are fully responsible for understanding your insurance policy and coverage.** If you do not have health insurance, we offer self pay options. **Self pay options are NON REFUNDABLE and valid for 1 year.**

2. **Referrals**: If your insurance requires a referral for a specialist, it is your responsibility to provide us with the referral dated the day of your first visit from your Primary Care Physician (PCP). We are not able to request a referral from your PCP or insurance. If you do not have the referral at the time of your visit, your appointment will be rescheduled until we have the referral. If you are unsure if you require a referral or have any other questions concerning your insurance, we suggest you contact your insurance company. **Knowing your insurance benefits is your responsibility.**

3. **Co-Payments and Deductibles**: All co-payments and deductibles must be paid **at the time of service.** This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles from patients can be considered fraud.

4. **Claims Submission**: We will submit your claims and assist you in any way we reasonably can to help get your claim paid. If your insurance company needs you to supply certain information directly, it is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. **If your insurance company does not pay your claim within 60 days, the balance will be automatically billed to you.** Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.

5. **Collections**: Unpaid balances will be sent to collections. If your balance is sent to collections, you will be responsible for 33% of your balance in addition to the original account balance plus any fees and interest charged to you by the collection agency.

6. **Unauthorized Audio or Video Recording -** In order to ensure every patient's privacy there is to be no unauthorized audio or video recording. If for any reason you feel you need to record any part of your visit it will need to be cleared by the HCR Staff.

7. **Missed, Cancelled, Rescheduled Appointments -** If you are 15 or more minutes late for your appointment, we may not be able to treat you at that time. In order for all of our patients to receive quality treatment and attentiveness from the providers, the treatment schedules are very time sensitive. If you miss, cancel, or reschedule your appointment within 24 hours of your scheduled time there is a $35 fee.

8. **Shared Patient Data -** Please be advised that all information provided to Virginia Sports Chiropractic and Haymarket Chiropractic Rehabilitation may be used for health, information, and billing purposes interchangeably between these different office locations if necessary.