EASTERN SHORE CHIROPRACTIC & SPORTS CLINIC
22806 U.S. Hwy 98
FAIRHOPE AL 36532 (251-990-8383)

Dr. Stephanie Harrison, DC
Dr. Tobie Southall, DC
Dr. Justin Southall, DC

Confidential Patient Health Record

***Today's Date*:____/____/_____**

Whom may we thank for referring you? _____

Personal Information

Last:_____ First:_____ Middle: _____

Birth Date: ____ /____/_____ Age:_____ Sex: Male / Female SSN: _____

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated

Address: _____Apt # _____

City: _____ State: _____ Zip: _____ Country: _____ County: _____

Home Phone: (_____) _____-_____ ext _____ Work Phone: (_____) _____-_____ ext _____

Cell Phone: (_____) _____-_____ ext _____ Fax #: (_____) _____-_____ ext _____

Email Address: _____ Spouses Name: _____

Emergency Contact

Last:_____ First:_____Middle:_____

Relationship: □ Spouse □ Relative □ Friend □ Other _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Employment Information

Business Name: _____

Phone: (_____) _____-_____ Fax #: (_____) _____-_____

Employer's Email Address: _____

Occupation/Job Title: _____ Job Description _____

SECTION 1 MAIN COMPLAINT/HEALTH CONDITION QUESTIONS

Main Complaint or 1st Problem area (Where is it located?):_____

Is your problem the result of ANY type of work related or car accident? Yes or No **If YES, date of work injury or car accident?_____**

Please describe the onset (how did it this complaint happen?)_____

When did this problem begin (DATE THIS BEGAN)? _____

What have you done since the onset? Nothing Urgent Care Rest Ice Heat OTC medications RX medications Primary Care Doctor Massage Chiropractic or Physical therapy

Describe the frequency (Choose one): □ Constant □Frequent □ Intermittent

How would you describe the pain (check all that apply): □Aching □Burning □Deep □Dull □Pulling □Sharp □Stiff □Shooting □Stabbing □Tight □Numbness □Tingling □Weakness □Other_____

Does it radiate to any other locations? Yes or No If yes, please describe:_____

Dr. Stephanie Harrison_____
Dr. Tobie Southall_____
Dr. Justin Southall_____

Patient Name: _____ Date:_____

Are headaches present? Yes or No Describe: Tension Sinus Migraine Cluster

On a scale of 0 to 10 (10 being the worst pain and 0 being no pain) rate your above complaints by circling the number:

1st complaint only: 0 1 2 3 4 5 6 7 8 9 10

What makes your symptoms BETTER? Nothing Rest Ice Heat OTC medications RX medications Massage Chiropractic or Physical therapy

What makes your symptoms WORSE? Sitting sleeping driving standing walking lifting running any movement

Have you experienced this condition or any other similar conditions in the PAST? Yes or No

If yes, when was the last time? _____**What treatment did you receive**? _____

By whom: _____

Have you had any RECENT X-Rays, labs or diagnostic testing? Yes or No If yes, please describe:

_____

ACTIVITIES OF DAILY LIVING – PLEASE CHOOSE NO MORE THAN 2 and DESCRIBE HOW LONG YOU CAN PERFORM BEFORE THE SYMPTOMS START

□Sleeping: How long before problem starts? _____
□Driving: How long before problem starts? _____
□Lifting: How long before problem starts? _____
□Standing: How long before problem starts? _____
□Sitting: How long before problem starts? _____
□OTHER_____ How long before problem starts? _____

Patient Name: _____ Date:_____

Do you have a SECOND complaint or health condition which you are now consulting us with? YES or NO
If yes please continue with section 2 if NO skip to REVIEW OF SYSTEMS on page 4.

SECTION 2 SECOND COMPLAINT/HEALTH CONDITION QUESTIONS

2nd Complaint area (Where is it located?):_____

Is your problem the result of ANY type of work related or car accident? Yes or No **If YES, date of work injury or car accident?_____**

Please describe the onset (how did it this complaint happen?)_____

When did this problem begin (DATE THIS BEGAN)? _____

What have you done since the onset? Nothing Urgent Care Rest Ice Heat OTC medications RX medications Primary Care Doctor Massage Chiropractic or Physical therapy

Describe the frequency (Choose one): □ Constant □Frequent □ Intermittent

How would you describe the pain (check all that apply): □Aching □Burning □Deep □Dull □Pulling □Sharp □Stiff □Shooting □Stabbing □Tight □Numbness □Tingling □Weakness □Other_____

Does it radiate to any other locations? Yes or No If yes, please describe:_____

Are headaches present? Yes or No Describe: Tension Sinus Migraine Cluster

On a scale of 0 to 10 (10 being the worst pain and 0 being no pain) rate your above complaints by circling the number:

2nd complaint Pain levels: 0 1 2 3 4 5 6 7 8 9 10

What makes your symptoms feel BETTER? Rest Ice Heat OTC medications RX medications Massage Chiropractic or Physical therapy

What makes your symptoms feel WORSE? Sitting sleeping driving standing walking lifting running

Have you experienced this condition or any other similar conditions in the PAST? Yes or No

If yes, when was the last time? _____**What treatment did you receive**? _____

By whom: _____

Have you had any RECENT xrays, labs or diagnostic testing? Yes or No If yes, please list:_____

ACTIVITIES OF DAILY LIVING – PLEASE CHOOSE NO MORE THAN 2 and DESCRIBE HOW LONG YOU CAN PERFORM BEFORE THE SYMPTOMS START

□Sleeping: How long before problem starts? _____
□Driving: How long before problem starts? _____
□Lifting: How long before problem starts? _____
□Standing: How long before problem starts? _____
□Sitting: How long before problem starts? _____
□OTHER_____ How long before problem starts? _____

Patient Name: _____ Date:_____

3. REVIEW of SYSTEMS: Below is a list of symptoms that may seem unrelated to the purpose of your appointment. These questions must be answered carefully as the problems can affect your overall course of care.

Musculoskeletal: ☐ **I DENY having any of the symptoms or problems listed below now or in the past.**

☐ **osteoarthritis** ☐ **degenerative disc** ☐ **osteoporosis** ☐ **joint replacement**
☐ **osteopenia** ☐ **Rheumatoid arthr** ☐ **degenerative disc disease**

Neurologic System: ☐ **I DENY having any of the symptoms or problems listed below now or in the past.**

☐ **dizziness** ☐ **limb weakness** ☐ **numbness** ☐ **slurred speech** ☐ **tremor**
☐ **facial weakness** ☐ **loss of consciousness** ☐ **seizures** ☐ **anxiety/depression** ☐ **loss of balance**
☐ **headache** ☐ **loss of memory** ☐ **sleep disturbance** ☐ **strokes**

Ears, Nose and Throat: ☐ **I DENY having any of the symptoms or problems listed below now or in the past.**

☐ **bleeding** ☐ **ear drainage** ☐ **hearing loss** ☐ **nosebleeds** ☐ **sore throat**
☐ **dentures** ☐ **ear pain** ☐ **history of head injury** ☐ **postnasal drip** ☐ **tinnitus (ringing in ears)**
☐ **difficulty swallowing** ☐ **fainting** ☐ **hoarseness** ☐ **rhinorrhea (runny nose)** ☐ **TMJ problems**
☐ **discharge** ☐ **frequent sore throats** ☐ **loss of sense of smell** ☐ **sinus infections**
☐ **dizziness** ☐ **headaches/migraine** ☐ **nasal congestion** ☐ **snoring**

Cardiovascular: ☐ **I DENY having any of the symptoms or problems listed below** now or in the past**.**

☐ **angina (chest pain or discomfort)** ☐ **high blood pressure** ☐ **shortness of breath with exertion or exercise**
☐ **chest pain** ☐ **low blood pressure** ☐ **swelling of legs**
☐ **claudication (leg pain/ache)** ☐ **orthopnea (difficulty breathing lying down)** ☐ **ulcers**
☐ **heart murmur** ☐ **palpitations** ☐ **varicose veins**
☐ **heart problems** ☐ **Pacemaker or Defibrillator**

Respiration: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **asthma** ☐ **coughing up blood** ☐ **sputum production**
☐ **cough** ☐ **shortness of breath** ☐ **wheezing**

Gastrointestinal: ☐ **I DENY having any of the symptoms or problems listed below now or in the past.**

☐ **constipation** ☐ **abdominal pain** ☐ **indigestion/reflux** ☐ **abnormal stool** ☐_____
☐ **diarrhea** ☐ **bloating** ☐ **nausea** ☐ **abnormal vomiting**

Eyes/Vision: ☐ **I DENY having any of the symptoms or problems listed below now or in the past.**

☐ **blindness** ☐ **change in vision** ☐ **field cuts** ☐ **photophobia**
☐ **blurred vision** ☐ **double vision** ☐ **glaucoma** ☐ **tearing**
☐ **cataracts** ☐ **eye pain** ☐ **itching** ☐ **wear glasses/contacts**

Endocrine: ☐ **I DENY having any of the symptoms or problems listed below now or in the past.**

☐ **cold intolerance** ☐ **excessive hunger** ☐ **goiter** ☐ **unusual hair growth**
☐ **diabetes** ☐ **excessive thirst** ☐ **hair loss** ☐ **voice changes**
☐ **excessive appetite** ☐ **abnormal frequency of urination** ☐ **heat intolerance**

Patient Name: _____ Date:_____

Skin: ☐ **I DENY having any of the symptoms or problems listed below now or in the past.**

☐ changes in nail texture ☐ hair loss ☐ itching ☐ skin lesions / ulcers
☐ changes in skin color ☐ hives ☐ paresthesias ☐ varicosities
☐ hair growth ☐ history of skin disorders ☐ rash

Allergy: ☐ **I DENY having any of the symptoms or problems listed below now or in the past.**

☐ anaphalaxis ☐ itching ☐ environmental ☐ animals
☐ food intolerance ☐ nasal congestion ☐ rash

Hematologic: ☐ **I DENY having any of the symptoms or problems listed below now or in the past.**

☐ anemia ☐ blood clotting ☐ bruising easily ☐ lymph node swelling
☐ bleeding ☐ blood transfusion ☐ fatigue

Constitutional: ☐ **I DENY having any of the symptoms or problems listed below now or in the past.**

☐ chills ☐ fatigue ☐ night sweats ☐ weight loss
☐ daytime drowsiness ☐ fever ☐ weight gain

---

4. PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Current Medication (s): **List ANY/ALL medications you are CURRENTLY taking. Be Specific.**

Medication	Dosage	For What Condition?	How long have you been taking this?

Current Illness(es): **LIST all health conditions. CIRCLE all CURRENT conditions.**

☐ ADD/ADHD ☐ cystic kidney disease ☐ hypertension ☐ psychiatric problems
☐ Alzheimers ☐ depression ☐ influenzal pneumonia ☐ scoliosis
☐ anemia ☐ Diabetes (insulin dep) ☐ liver disease ☐ seizures
☐ arthritis ☐ Diabetes (non insulin) ☐ lung disease ☐ shingles
☐ asthma ☐ eczema ☐ lupus erythema (discoid) ☐ past history of similar symptoms
☐ cancer ☐ emphysema ☐ lupus erythema (systemic) ☐ STD's (unspecified)
☐ Cerebral palsy ☐ eye problems ☐ multiple sclerosis ☐ suicide attempt(s)
☐ COPD ☐ fibromyalgia ☐ Parkinson's disease ☐ thyroid problems
☐ Crohn's/colitis ☐ heart disease ☐ unspecified pleural effusion ☐ vertigo
☐ CRPS (RSD) ☐ hepatitis ☐ pneumonia ☐ other:_____
☐ CVA (stroke) ☐ HIV ☐ psoriasis

Surgery (ies): **LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

Patient Name: _____ Date:_____

Injury (ies): **Mark or List All Injuries. Write the DATE of the Injury immediately afterward.**

☐ back injury	☐ head injury (loss of consciousness)	☐ motor vehicle accident
☐ broken bones	☐ head injury (no loss of consciousness)	☐ soft tissue injury (mild)
☐ disability (ies)	☐ industrial accident	☐ soft tissue injury (moderate)
☐ fall (severe)	☐ joint injury	☐ soft tissue injury (severe)
☐ fracture	☐ laceration (severe)	☐ other:

Family History: **Mark all that apply below. List any specific conditions past or present after has/had:**

general family	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
father	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
mother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
son (s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
daughter(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
brother(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
sister(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____

Social History

Alcohol: ☐ Never ☐ Social Consumption only ☐ Beer ☐ Liquor ☐ Wine ; _____ oz ____ glasses; ☐ Day ☐ Week ☐ Month

Diet (please mark all that apply): ☐ High Fat ☐ High Fiber ☐ High Protein ☐ High Salt ☐ Low Calorie ☐ Low Carb ☐ Low Fiber ☐ Low Salt ☐ Low Sugar

Tobacco: ☐ Deny Tobacco Use ☐ Do not smoke cigars, cigarettes or pipe ☐ Live with a smoker ☐ Quit smoking

☐ Smoke; # _____ per ☐ Day ☐ Week ☐ Month ☐ Chew; #_____cans per ☐ Day ☐ Week ☐ Year

---

Initials: _____ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is separate and distinct healing art from medicine and does not proclaim to cure any named disease.

Initials:_____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials:_____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period_____

Initials:_____ I grant permission to be called to confirm or reschedule an appointment and to be sent emails or health information to me as an extension of my care in this office.

Initials:_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials:_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: _____ Date: _____

Patient's Signature: _____ Date: _____

Patient Name: _____ Date:_____

Functional Rating Index

Today's Date: ___-___-___
Patients Name: _____

Instructions

We are interested in knowing whether you are having any difficulty at all with the activities listed below. Please circle **one** answer for each activity.

	0	1	2	3	4
1. Pain Intensity	No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain
2. Sleeping	Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed Sleep	Greatly Disturbed Sleep	Totally Disturbed Sleep
3. Personal Care (washing, dressing etc.)	No Pain; No Restrictions	Mild Pain; No Restrictions	Moderate Pain; Need to go Slowly	Moderate Pain; Need Some Assistance	Severe Pain; Need 100% Assistance
4. Travel (driving, etc.)	No Pain on Long Trips	Mild Pain on Long Trips	Moderate Pain on Long Trips	Moderate Pain on Short Trips	Severe Pain; Need 100% Assistance
5. Work	Can do Usual Work Plus Unlimited Extra Work	Can do Usual Work no Extra Work	Can do 50% of Usual Work	Can do 25% of Usual Work	Cannot Work
6. Recreation	Can do all Activities	Can do Most Activities	Can do Some Activities	Can do a Few	Cannot do Any Activities
7. Frequency of Pain	No Pain	Occasional Pain; 25% of the Day	Intermittent Pain; 50% of the Day	Frequent Pain; 75% of the Day	Constant Pain; 100% of the Day
8. Lifting	No Pain with Heavy Weight	Increased Pain with Heavy Weight	Increased Pain with Moderate Weight	Increased Pain with Light Weight	Increased Pain with Any Weight
9. Walking	No Pain; Any Distance	Increased Pain After 1 Mile	Increased Pain After ½ Mile	Increased Pain After ¼ mile	Increased Pain with All Walking
10. Standing	No Pain After Several Hours	Increased Pain After Several Hours	Increased Pain After 1 Hour	Increased Pain After ½ Hour	Increased Pain with Any Standing

Patient Name: _____ Date:_____

Eastern Shore Chiropractic and Sports Clinic

Informed Consent for Chiropractic Treatment

You have the right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give your consent to treatment.

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, laser and acupuncture/dry needling. The chiropractic treatment may be performed by any of the Doctors of Chiropractic working at Eastern Shore chiropractic and Sports Clinic. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a back up for the doctors at Eastern Shore Chiropractic and Sports Clinic.

I have had the opportunity to discuss with the doctor my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that there are some risks to chiropractic treatment including but not limited to:

- Broken bones
- Dislocations
- Sprains/strains
- Burns or frostbite (physical therapy)
- Worsening/aggravation of spinal conditions
- Increased symptoms/pain
- No improvement of symptoms or pain
- Infection (acupuncture/dry needling)
- Punctured lung (acupuncture/dry needling)
- Other _____

In rare cases there have been reported complications of arterial dissections n (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

Patient name: _____

Patient signature or representative: _____

Date: _____

Witness to patient signature: _____

Patient Name: _____ Date:_____

EASTERN SHORE CHIROPRACTIC AND SPORTS CLINIC

Authorization for Verbal Communication, to Leave Voicemail Messages, and/or Receive Emails Regarding My Personal Health Information

This does not authorize release of medical records without a signed authorization to release medical records by patient or guardian

PATIENT INFORMATION:

Patient Name: _____ Birth Date: _____-_____-_____

INFORMATION TO BE DISCLOSED: Verbal communication only regarding patients care-no copies of medical records provided

PLEASE PROVIDE YOUR CURRENT TELEPHONE NUMBERS WHERE WE HAVE PERMISSION TO CALL AND/OR LEAVE A CONFIDENTIAL VOICEMAIL:

Home Phone: _____ Cell phone: _____

Work Phone: _____ Other Phone: _____

We normally contact our patients between 8 a.m. and 5 p.m. Monday through Friday. Please check below where you would prefer to be contacted during these hours:

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Other Phone: _____

If we need to contact you after hours, please check below where you prefer to be called:

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Other Phone: _____

YOUR PROTECTED HEALTH INFORMATION DESIGNEES:

If you are not available at the time that we call, please list below those individuals (designees) with whom we can leave a message or briefly discuss your medical information. This person (designee) will also be able to call the office on your behalf.

PLEASE PRINT THE NAME AND RELATIONSHIP TO YOU/PATIENT OF EACH DESIGNEE BELOW:

Designee Name: _____ Relationship to patient: _____

Designee Name: _____ Relationship to patient: _____

_____ **CHECK HERE IF YOU *DO NOT* WANT YOU HEALTH CARE INFORMATION DISCUSSED WITH ANYONE OTHER THAN YOURSELF.**

APPOINTMENT REMINDERS:

If you would like to be set up for appointment reminders, please list a cell phone number and provider OR email address.

(Cell phone provider required for text reminders!)

Cell phone number: _____ Cell phone provider: _____

OR Email address: _____

CONFIDENTIAL EMAIL:

PLEASE WRITE BELOW AN EMAIL ADDRESS THAT WE CAN SEND EDUCATIONAL INFORMATION PERTAINING TO YOUR TREATMENT PLAN/GOALS (STRETCHES, EXCERSICES, ETC.):

_____

YOUR SIGNATURE BELOW CONFIRMS YOUR APPROVAL OF THESE UPDATED HIPAA COMMUNICATIONS PREFERENCES. YOU MAY CHANGE YOUR SELECTIONS AT ANY TIME, BUT MUST DO SO IN WRITING BY COMPLETEING AN UPDATED FORM.

Patient Signature: _____ Date: _____-_____-_____

Witness: _____ Date: _____-_____-_____

Patient Name: _____ Date:_____

OFFICE POLICY

We believe that a clear definition of our office policies will allow YOU, the patient, and Us, the doctor, to concentrate on the big issue – **REGAINING AND MAINTAINING YOUR HEALTH**.

APPOINTMENT POLICY

Regardless of how many appointments are scheduled for you each week, please note that it is the frequency of visits that count, not the days on which you receive the service.
This office reserves the right to charge $70 for no call/no show appointments, as there are other patients that may need those appointment times. If, for any reason, you are unable to keep an appointment and can't reschedule with 24 hours' notice, we require that you telephone immediately to reschedule that visit; we typically can fill your appointment time within at least 1 hours' notice. If it is after office hours you may leave a message on our voicemail at 251-990-8383. If there are 3 missed appointments/no call no shows in a row you could be dismissed from care.
When entering the office on any given visit, please go directly to the front desk and "sign in". We sincerely attempt to honor all appointments at the scheduled time. If you are more than 10 minutes late for your appointment, you may be asked to wait for the next available appointment; we cannot guarantee how long you may have to wait to be seen or which doctor will be able to see you.

FINANCIAL POLICY

1. It is our policy that all services rendered in this office are charged directly to you, the patient, and that you are personally responsible for all payments whether or not the office accepts insurance assignment.
2. All payments are expected at the time of services or at the end of the week. Patient balances may not exceed $150.00 at any time.
3. All insurance assignment patients must pay their deductible in full and the co-pay/co-insurance at the time of service or at the end of the week.
4. There will be a $35.00 fee imposed for all checks returned to this office.
5. Returned checks and balances over 30 days may be subject to additional collection fees and interest charges of 1.5% per month. Charges may also be made for missed appointments and those, cancelled without a 24-hour notice.

A detailed policy manual has been given to me. I have read and understand all the policies.

Signature _____ Date_____

Patient Name: _____ Date:_____

EASTERNSHORE CHIROPRACTIC AND SPORTS CLINIC
22806 US HWY 98
FAIRHOPE, AL 36532
251-990-8383

OFFICE POLICIES FOR PATIENTS

Patient Name: _____ Date:_____

APPOINTMENT POLICY

Office visits are scheduled according to the severity of your condition and the program of chiropractic care that the doctor feels is best for you. Since your condition requires numerous appointments over the next few weeks or months, we have designed a multiple appointment program for your convenience. This procedure minimizes your time in the office and facilitates incorporating your appointments into your daily routine.

The frequency of your visitation schedule is of paramount importance to your results, so we ask that each patient assume the responsibility of strict adherence to the appointment program as it is designed for optimum results for you.

We also run a no wait clinic (we don't like to make our patients wait); in order for us to continue with this benefit you need to arrive for your appointments on time.

Missed/Rescheduled Appointments

Regardless of how many appointments are scheduled for you each week, please note that it is the frequency of visits that count, not the days on which you receive the service. This office reserves the right to charge $70 for no call/no show appointments, as there are other patients that may need those appointment times. If, for any reason, you are unable to keep an appointment and can't reschedule with 24 hours' notice, we require that you telephone immediately to reschedule that visit; we typically can fill your appointment time within at least 1 hours' notice. If it is after office hours you may leave a message on our voicemail at 251-990-8383. If there are 3 missed appointments/no call no shows in a row you could be dismissed from care.

When entering the office on any given visit, please go directly to the front desk and "sign in". We sincerely attempt to honor all appointments at the scheduled time. If you are more than 10 minutes late for your appointment, you may be asked to wait for the next available appointment; we cannot guarantee how long you may have to wait to be seen or which doctor will be able to see you. The doctors are often requested for speaking engagements and corporate ART work and very commonly have to leave the office quickly in the afternoon. If you are running late, please contact the office immediately. We cannot ensure the doctors will be here after your scheduled appointment time. If we are unexpectedly running behind, we will try to contact you and advise you on the status of your appointment time. If you have any questions regarding our office policy or your appointments, please do not hesitate to ask.

EMERGENCY NUMBERS

In case of non-life threatening emergencies such as flare ups, falls, or injuries, please call the office at 251-990-8383. The doctors may not be able to see you right away, but the doctor can give you recommendations until they can. Please call if any of the above occurs to you or your family.

CELL PHONES

Some of our patients experience migraines and/or other problems provoked by the tone of a cellphone. For this reason, we ask that you turn your cell phone to silent upon entering the office.

Patient Name: _____ Date:_____

There is no talking on cell phones while in the office, especially in treatment areas, as this may interfere with our equipment and is disrespectful to the doctor treating you.

KIDS

We are a family oriented office, but due to the conditions we commonly treat (headaches, migraines, etc.) we ask that if your child in under 10 years of age, they are not left in the treatment areas unsupervised.

FINANCIAL POLICY

Patients must understand that ultimately they are financially responsible for professional services rendered. We do not bill patients. If we are forced to bill you, a $15 book keeping service fee will be added.

- It is the policy of this office that all services rendered are charged directly to you, the patient, and that ultimately the patient is responsible for all services including those not reimbursed by third party payers.
- All payments are expected at the time of service. Patient balances are not to exceed $150.00 at any time.
- All insurance assignment patients must pay their deductibles in full and the copayments at the time of service.
- Returned checks and balances over 30 days may be subject to additional collection fees and interest charges of 1.5% per month. Charges may also be made for missed appointments and those cancelled without 24 hours' notice.
- All accounts not paid within 90 days will automatically be put through collections.

CASH POLICY

This policy is very simple-all services must be paid at the time they are rendered.

INSURANCE POLICY

- The privilege of insurance assignment begins when out office receives your insurance forms.
- All deductible payments MUST be made prior to insurance submittal.
- You are considered to be a cash patient until our office qualifies your coverage to determine the extent of benefits under your policy.
- All copayments are payable when the services are rendered. A $150.00 balance must not be exceeded by any patient. Services may be declined if balance has been exceeded.
- All patients whose visitation schedule is once per month will not be eligible for insurance assignment. Charges for services will again be due as they are received.

Patient Name: _____ Date:_____

- Should you discontinue care for any reason other than discharge by the doctor, any and all balances due will become immediately payable in full, regardless of any claims submitted.
- This office does not promise that an insurance company will reimburse you for the usual and customary charges submitted by this office, nor will we enter into any dispute with an insurance company over the amount of reimbursement.
- Since we do not own your policy and occasionally will experience difficulty in collection from the carrier, we may ask for your active assistance in rectifying this situation.