



Patricia L. Snair, D.C.
Director

CONFIDENTIAL NEW PATIENT INFORMATION

Date: _____
Legal Name: _____ SS#: _____
Name I prefer to be called: _____ Phone #: _____
Cell#: _____ Driver's License #: _____
E-mail Address: _____
Gender: M F Age: _____ Date of Birth: ____/____/____
Marital Status: Single Married Other Spouse Name: _____
Local Address: _____
City: _____ State: _____ Zip Code: _____
Employment Status: _____
Employer Name: _____

Work Address/ City/ State/ Zip

Type of Work: _____ Work #: _____

In Event of Emergency:

Contact Name: _____ Relationship: _____
Home #: _____ Work #: _____
How did you hear about our office?: _____

Please answer the following questions so that we may better care for you.

- I have a problem/symptom (circle one) and I am ONLY interested in help with this specific problem.
- I have a problem/symptom (circle one) and I am interested in help with this problem and in learning how to prevent it in the future.
- I have a problem/ symptom (circle one) and I am interested in help with this problem in addition I am interested in learning about health potential and the role of Chiropractic care in improving my health and my family's health as well.
- I have no special problem, I understand the role of Chiropractic care in my general healthcare.

Who is your primary care physician? _____
Name

Address: _____ City/State/Zip: _____

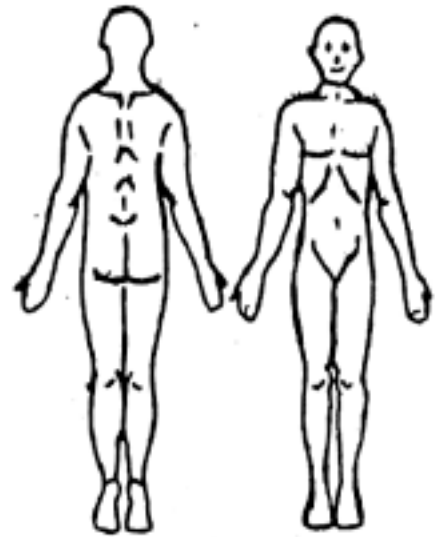
Do you want us to forward initial visit information to your Primary Care Physician? No Yes

Previous Chiropractic History

Have you ever been to a Doctor of Chiropractic before? No Yes
If yes, when was the approximate date of your last adjustment? _____
Doctor's name and address: _____
Have you had Therapeutic Massage before? No Yes

MAJOR AREA OF COMPLAINT: (Circle areas of discomfort)

Describer Symptoms: _____



Do you know what may have caused this complaint?
 Auto Work Fall Unknown

Has it been bothering you for more than a couple of days?
 No Yes How long? _____

Do you smoke tobacco? No Yes If yes, how much? _____

Do you drink alcohol? If yes, how often?
 Never Very Seldom Social 1 drink/day 2-5 drinks/day

Do you have any allergies to medications? (Prescription and/or OTC) If yes, what?

Do you have any other allergies or adverse reactions? _____

Please write any other information you might feel is pertinent to today's visit: _____

Office Policy:

1. All fees are due at the time of services rendered unless other arrangements have been made.
2. Each patient is responsible for payment of our fees.
3. In case of any new injury, please notify the office of injury/accident prior to making an appointment.
4. Patients are scheduled by appointments. If you are late you have missed your appointment time and will be worked in the schedule as best as we can.
5. Any payment plans are to be discussed with the Office Manager.

Release and Assignment:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctors' office will prepare any necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____



**RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN
ACKNOWLEDGEMENT FORM**

Back N' Balance, Inc.

I, _____ have reviewed/ received a copy of Back N' Balance's Notice of Patient Privacy Practices.

Signature of Patient or Parent or Legal Guardian

Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:

Initials:

Reason:

NOTICE THESE FORMS ARE AVAILABLE UPON REQUEST

- | | |
|--|----------|
| 1. Notice of Privacy Practices Hand-outs | #HIPAA01 |
| 2. Patient Authorization for Use and Disclosure of Protected Health Information to Third Parties | #HIPAA40 |
| 3. Request for Limitations and Restrictions of Protected Health Information | #HIPAA33 |
| 4. Request to Inspect and Copy Protected Health Information | #HIPAA38 |
| 5. Request for Correction/ Amendment of Protected Health Information | #HIPAA36 |
| 6. Request for an Accounting of Certain Disclosures of Protected Health Information | #HIPAA42 |
| 7. Patient Complaint Form | #HIPAA18 |

Back N' Balance

As a courtesy to our patients we file insurance claim forms for you.

It is however your responsibility to give us your insurance information. This includes a copy of your most recent insurance card and a claim number if auto related. We can not provide service without this information

Please know that verification of benefits is not a guarantee of payment. Claims are paid in accordance to the written terms of your contract. It is important that you know your insurance policy.

Date: _____/_____/20____

Signature: _____

Print Name: _____

MASSAGE, PHYSICAL THERAPY & NUTRITIONAL COUNSELING POLICY

Our clinic offers massage, physical therapy and nutritional counseling services, which have been recommended for you by your doctor, who feels it is clinically necessary for your care and treatment. Our policies are outlined here and we ask that you read this carefully and sign it, as this will become part of your permanent record. If you have any questions, please feel free to ask them before signing this form. **You are fully responsible for the bill from services received. Services will be paid for at the time of your appointment.**

INSURANCE BILLING

Our massage therapists are under contract with our naturopaths and chiropractors; therefore billings are submitted under his or her name and license. If you are unsure of your policy benefits we advise you to contact your insurance company. All policies are different and we do not guarantee coverage. Generally, if your policy states that services provided are **“under the direct supervision of a covered physician”** those services should be covered. For massage, the procedural codes we are required to use for these services are listed as **“Therapeutic Procedures”** classified under physical medicine/ rehabilitation and broken down into timed increments of 15-minutes each for a total of 60 or 30 minute massages. As a courtesy, we will bill your insurance plan for massage or physical therapy sessions. Nutritional counseling services are not billable to insurance plans. Payments for nutritional counseling are required at the time services are rendered.

**MASSAGES, PHYSICAL THERAPY AND NUTRITIONAL COUNSELING CANCELLATION/
NO-SHOW/ LATE FEE POLICY**

When you make a massage, physical therapy or nutritional counseling appointment, that time is set-aside specifically for you by our therapists. Because we often have a waiting list for these appointments, we ask that you give 24 hours cancellation notice so that someone else can be scheduled for that time slot. In the event of a no-show or cancellation without 24 hours notice, you will be charged 50% of your appointment fee. Massage and nutritional counseling appointments will not be scheduled until the fee is paid. If you arrive more than 15 minutes late for an appointment, you will be billed directly for 50% of the charges. **The appointment session will be shortened to compensate. We will not bill your insurance company for any cancellation or late fees.**

Thank you for your time and attention, please sign and date in the spaces provided below.

Patient Signature

Date

Print Name

Witness Signature

Date



Name: _____

Date: _____ / _____ / _____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, there are many conditions that respond favorably when treatment is given that increases your body's ability to function correctly. This office specializes in such treatment and if you wish, an individualized program will be suggested. Please check the symptoms you have experienced in either (or both) of the chronic (recurrent symptoms) or acute (symptoms you have now). Leave the question blank if neither acute or chronic symptoms are present.

Part 1: Gastrointestinal

_____	_____	Digestive complaints
_____	_____	Stomach complaints
_____	_____	Ulcers
_____	_____	Frequent Heartburn
_____	_____	Nausea
_____	_____	Frequent Diarrhea
_____	_____	Frequent Constipation
_____	_____	Irritable Bowel
_____	_____	Hemorrhoids
_____	_____	Frequent Vomiting
_____	_____	Colitis/ diverticulitis
_____	_____	Black or bloody stool
_____	_____	Gallbladder trouble
_____	_____	Frequent burping/ belching

Part 2: Immune Response

_____	_____	Frequently sick
_____	_____	Frequent swollen glands
_____	_____	Frequent sore throats
_____	_____	Depression and/ or anxiety
_____	_____	Achy joints/ muscle pain
_____	_____	Headaches/ migraines
_____	_____	Recurrent digestive complaints
_____	_____	Chronic fatigue
_____	_____	Food allergies
_____	_____	Eczema or hives
_____	_____	Allergies:mild/moderate/severe

Part 3: Structural/ Neurological

_____	_____	Headaches
_____	_____	Muscle cramps/ muscle spasm
_____	_____	Neck pain
_____	_____	Jaw pain
_____	_____	Dizziness
_____	_____	Back pain
_____	_____	Shoulder/ elbow/ wrist pain
_____	_____	Numbness/ Tingling
_____	_____	Tremors in hand or feet
_____	_____	Knee or hip pain
_____	_____	Joint pain or loss of function
_____	_____	Osteoporosis/ osteomalacia
_____	_____	Current bone fracture or injury
_____	_____	Tendonitis/ Bursitis

Part 4: Cardiovascular

_____	_____	Irregular heartbeat
_____	_____	Heart murmur/palpitations
_____	_____	High or low blood pressure
_____	_____	Chest pain
_____	_____	Previous heart trouble
_____	_____	Poor circulation
_____	_____	Previous heart surgery
_____	_____	Varicose or spider veins
_____	_____	Hands or feet cold all the time

Part 5: Respiratory

_____	_____	Chronic cough
_____	_____	Asthma
_____	_____	Emphysema
_____	_____	Recurrent head colds
_____	_____	Recurrent sinus infections
_____	_____	Recurrent bronchitis
_____	_____	Smoker

Part 6: Genito- Urinary

_____	_____	Too frequent urination
_____	_____	Discolored or foul smelling
_____	_____	Blood in urine
_____	_____	Recurrent kidney infections
_____	_____	Recurrent bladder infections
_____	_____	Kidney stones
_____	_____	Bedwetting
_____	_____	Inability to control bladder

Part 7: Eyes/ Ears

_____	_____	Recurrent ear infections
_____	_____	Eye infection
_____	_____	Slowly losing vision
_____	_____	Floater in eyes
_____	_____	Glaucoma
_____	_____	Macular degeneration
_____	_____	Cataracts
_____	_____	Diabetic retinopathy

Part 8: For Men Only

_____	_____	Prostate Trouble
_____	_____	Urination problems
_____	_____	Reproductive problems

Part 9: For Women Only

_____	_____	Recurrent urinary tract inf
_____	_____	Yeast infections
_____	_____	Vaginal Discharge
_____	_____	Menstrual irregularity
_____	_____	Cramping
_____	_____	Mood swings
_____	_____	Depression
_____	_____	PMS
_____	_____	Infertility
_____	_____	Hot flashes
_____	_____	Currently taking hormone medication
_____	_____	Currently taking birth control pills
_____	_____	Lumps in breast
_____	_____	Uterine or ovarian cysts
_____	_____	Bladder leaks easily
_____	_____	Endometriosis

Part 10: Endocrine (Glandular)

_____	_____	Cold hands and feet
_____	_____	Low blood pressure
_____	_____	Weight problems (over or under)
_____	_____	Thyroid problems
_____	_____	Diabetes
_____	_____	Irritable if meals are Missed
_____	_____	Anxiety/ nervousness/ Irritability
_____	_____	Dizzy upon standing
_____	_____	Too quickly
_____	_____	Weak and shaky
_____	_____	Hyperactive behavior
_____	_____	Depression
_____	_____	Very susceptible to Infections
_____	_____	Frequent headaches
_____	_____	Digestive complaints

Back N' Balance

Terms Of acceptance

When a patient seeks chiropractic health care, and when a chiropractor accepts a patient for such care, it is essential that they are both seeking and working for the same goal.

Chiropractic has only one goal. It is therefore important that the patient understands the goal and the means that will be used to attain it. This will ensure that there is no confusion, misunderstanding or disappointment. The goal of chiropractic is to correct vertebral subluxations for the purpose of restoring the proper transmission of nerve energy over nerve pathways so that every part of the body may have proper nerve supply at all times. This allows the innate healing ability of the body to work at a maximum efficiency.

Patients usually want to get rid of whatever ailments or conditions are bothering them. This, however, is not the goal of chiropractic.

The purpose of chiropractic is to restore and maintain the mechanical integrity of the spinal cord and its nerve roots. These vital nerve pathways are housed in and protected by, the bones of the spine. Tiny misalignments of the vertebrae or bones of the spine, which interfere with the function of these nerve pathways, are called subluxations. They come from many causes and prevent various organs, glands and muscles from working properly. By means of chiropractic adjustments, subluxations are corrected, thus restoring normal nerve functions. With proper nerve supply, health improves. In some, symptoms clear up quickly. In others, the process is slower and in a few, it is only partial or not at all.

Regardless of what the disease is called, the chiropractor does not offer to heal or even treat it. Nor do they offer advice regarding the treatment of the disease. Their only goal is to allow the body to do its job. Their only means is the correction of the vertebral subluxations. They do not promise a cure from other diseases, nor offer treatment for other diseases.

I, _____ have read the above, understand it fully and undertake chiropractic care on this basis.

Signed _____ Date _____

Parental Release Form

I, _____ being parent/legal guardian (circle one) of _____, do hereby grant permission for him/her to receive care from a doctor at Back N' Balance. This shall include when necessary standard analysis, including X-rays and corrective spinal adjustments.

Patient Privacy Questionnaire

1. Please print the address of where you would like your billing statements, appointment reminders, test results, and/or correspondence from our office to be sent.

2. Please indicate if you would mind being in one of the rooms with the door open.

No, I do not mind _____ **Yes, I would like a private room only** _____

3. Please print the telephone numbers where you would want to receive calls about your appointment reminders, follow-up, test results or other health care information:

Phone Number: _____ Back-up: _____

*** I am fully aware that a cell phone is not a secure and private line**

4. Please list the names of any family and/or significant others whom we may inform about your medical condition and diagnosis. (Treatment, payment and health care operations) and in case of an emergency.

Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____

5. Can confidential messages (appointment reminders, etc.) be left on your telephone answering machine or voicemail?

Yes _____ **No** _____

Patient Name: _____
(Guardian if under 18 years)

Social Security Number: _____ - _____ - _____

Patient Signature: _____

Parent/ Guardian Signature: _____

Date: _____

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