ABSOLUTE WELLNESS CENTER

Welcome!

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name: ______________________________ SS #: ______________________________

Address: ______________________________ DOB: ______________________________

______________________________ Sex: (circle) male female

______________________________ Home #: ______________________________

Email address: ______________________________ Cell #: ______________________________

Employer: ______________________________ Work #: ______________________________

Address: ______________________________

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Whom may we thank for referring you to our office? ______________________________

Emergency Contact: ______________________________ Phone #: ______________________________

IF PATIENT IS A MINOR:

Parent name: ______________________________ Parent SS#: ______________________________

Parent DOB: ______________________________ Phone #: ______________________________

INSURANCE INFORMATION:

If you would like us to file your insurance for you as a courtesy, please allow the receptionist to copy your driver license and any insurance cards for policies you are currently covered under.

By signing below you authorize Absolute Wellness Center to release any medical information necessary to process your insurance claims. You authorize payment of medical benefits to Absolute Wellness Center for charges submitted on you or your dependant's behalf. You agree to pay charges not covered by your insurance company including (but not limited to) deductibles, co-payments, and coinsurance. You may, at any time, request and receive a copy of your account showing all charges and payments. You understand that this form will be kept on file and referred to any time insurance claims are to be filed.

Patient/parent signature: ______________________________ Date: ______________________________

ABSOLUTE WELLNESS CENTER

Date: ____/____/____ Patient name: ______________________________ Age: _______

Areas of complaint: ____

Place an "X" on the drawing below on areas causing you pain and a letter describing it

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES

PAIN SCALE
Please circle the number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10

NONE LITTLE MEDIUM SEVERE

Please list the dates of any automobile accidents or slip/fall injuries you have been involved in:

____

____

Please list the dates of ALL surgical operations and hospitalizations you have had:

____

____

Please list ALL medications (Rx and OTC) and any supplements you are taking:

____

____

For each of the conditions below place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present	
		Headaches
		Neck Pain
		Middle Back Pain
		Low Back Pain
		Pain in Arms
		Shoulder Pain
		Pain in Legs
		Foot/Ankle Pain
		Weakness
		Arthritis
		Numbness/Tingling
		Joint Swelling/Stiffness

Past	Present	
		Asthma
		Sinus Problems
		Allergies ___________
		Fibromyalgia
		Diabetes
		Anemia
		High Blood Pressure
		Epilepsy
		Nervousness/Depression
		Frequent Urination
		Premenstrual Syndrome
		Kidney Stones

Past	Present	
		Constipation
		Chest Pain
		Stroke
		Heart Disease
		Dizziness/Light Headed
		Tuberculosis
		Hepatitis A B or C
		AIDS/HIV
		Cancer
		Painful Urination
		Recent Weight Loss/Gain
		Other___________

FEMALES: LMP ____________ Pregnant? ______ Nursing? _____ Breast implants? ______

I certify with my signature that the information above is true and complete to the best of my knowledge. I also acknowledge that I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient/Guardian Signature ______________________________ Date: ____________

601 E. Whitestone Blvd., Ste. 230, Cedar Park, TX 78613
Phone (512) 528-1000 – Fax (512) 528-1200

Payment Policy

Absolute Wellness Center will gladly obtain your insurance benefits and file your insurance for your convenience. However, pre-approval of insurance is **not** a guarantee of payment. **By signing this Payment Policy you are stating that you clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between you and your insurance carrier.** In the event the insurance company refuses to pay for treatment, we will appeal the decision **two** times. If the insurance company continues to deny payment you are ultimately responsible for all fees and further insurance appeal becomes your responsibility.

Payment is expected at the time of service and we will take into consideration the estimated payments from your insurance company. You will be expected to pay your deductible and co-payment/coinsurance at the time of service.

______ If you are seeking treatment for a personal injury claim you will be expected to strictly adhere to a treatment plan. This plan will be discussed with you during your x-ray consultation and will be adjusted as needed. Your failure to adhere to the treatment plan will be reported to your attorney and/or the insurance company involved. This could result in the termination of your care due to non-compliance. If the insurance company refuses payment you will be held solely responsible for the full balance of the bill.

The office cannot carry a balance for longer than 60 days regardless of pending insurance payment. After 60 days we will inform you of the delinquent account and send out a billing statement due within 15 days. If no action is taken to clear the account, this office will be forced to employ a collection service to collect payment and any applicable late/collection fee's associated with the delinquency.

Our office is dedicated to providing all of our patients with optimal care. Please let us know if you have any concerns or questions. Thank you for choosing us for your chiropractic needs.

Sincerely,

Michaela "MJ" Kelley

I authorize Dr. Marc Richardson and the staff at Absolute Wellness Center to release any information concerning my case to my insurance company. I acknowledge that I have read and accept the terms of the above payment policy. I understand that payment is due at the time of treatment. I understand that parents/guardians are responsible for payment for services of minor children. I understand that I am responsible for all charges whether or not paid by the insurance company. Furthermore, I understand and agree that I will be charged $25 for each missed appointment should I fail to cancel a scheduled appointment 24 hours prior to appointment time.

____

Patient/Parent/Guardian Signature   Date