

Office Use: Date: _____ Acct#: _____ Doctor: _____ Case Type: _____

PATIENT PERSONAL INFORMATION:

Last Name: _____ Birth Date: _____ / _____ / _____
 First Name: _____ M. I. _____ Sex: _____ Male / Female
 Primary Address: _____ SSN: _____ - _____ - _____
 _____ Marital Status: _____ D / M / Sgl / Sep / Widow
 City: _____ Spouse's Name: _____
 State: _____ Zip: _____ Children's Names: _____
 Home Phone: _____
 Other Phone: _____ (mobile/ work /emergency) Who Referred You to our Office?: _____
 Email: _____

PATIENT EMPLOYER INFORMATION:

Name: _____
 Occupation: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Extension: _____
 Fax: _____
 Website: _____ Email: _____

PATIENT'S INSURANCE:

Who is responsible (not insurance) for payment of services rendered? Self Spouse Other _____
 Do you have secondary/supplemental insurance? Yes No
 Insurance Company Name: _____
 Policy Holders Name: _____ Relationship to Patient: _____
 Policy Holder's Date of Birth: _____ Policy Holder's Employer: _____

HISTORY:

Purpose of this appointment AND list your complaints: _____
 When did symptoms begin (this episode)? _____
 Please describe the circumstances which make the condition(s) better or worse?
 Better: _____
 Worse: _____
 If result of an accident, what type? Work Related Auto Other _____
 Have you seen any other doctor for this condition? Yes No If yes, who?: _____
 Have you been treated by a doctor for ANY health condition in the last year? Yes No
 If yes, please describe? _____

INSURANCE INFORMATION: I understand and agree that health and accident insurance policies are an agreement between and Insurance carrier and myself. Furthermore, I understand that this chiropractic 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 this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to 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 and treatment, any fees for professional services rendered to me will be immediately due and payable.

CONSENT OF PROFESSIONAL SERVICES: I Hereby authorize and release the doctor and whom ever he/she may designate to assist to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care or any clinic services that the doctor deems necessary in my case; and I further authorize him/her to disclose all or any part of my record to any person or corporation which is or may be liable under a contract to the clinic or to the patient, family member, or employer of the patient for all or part of the clinic's charge, including, but not limited to, hospital or medical service companies, insurance carriers, workers compensation carriers, welfare funds, or the patient's employer.

Signature Patient/Guardian/Guarantor:

Signature Physician:

X _____

X _____

CHECK EACH CONDITION THAT YOU ARE EXPERIENCING OR HAVE EXPERIENCED IN THE PAST

Name: _____ Date: _____

MUSCULO-SKELETAL SYSTEM

- Low Back Pain
- Mid Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Problems
- Leg Problems
- Swollen Joints
- Painful Joints
- Stiff Joints
- Sore Muscles
- Weak Muscles
- Walking Problems
- Hip Pain
- Broken Bones
- Shoulder Pain

HABITS

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Exercise
- Drug Abuse
- _____

SYMPTOM

GENITO-URINARY SYSTEM

- Bladder Trouble
- Excessive Urination
- Scanty Urination
- Painful Urination
- Discolored Urine
- Female
- Vaginal Discharge
- Vaginal Bleeding
- Vaginal Pain
- Breast Pain
- Lump(s) on the Breast

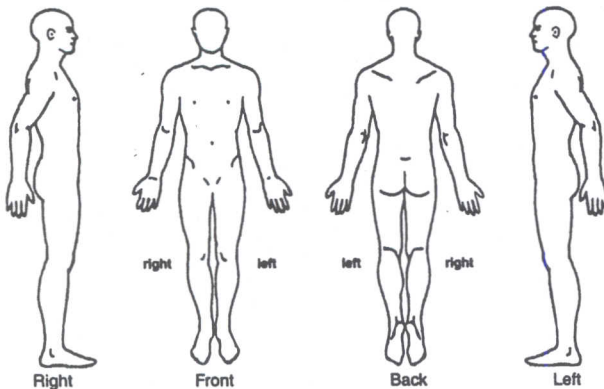
ARE YOU PREGNANT?
Check appropriate box & initial in blank line.

- Yes _____
- No _____

First Day of Last Menstrual
Period ____/____/____

LOCALIZATION

Mark area of your primary symptom with an "X"



GASTRO-INTESTINAL SYSTEM

- Poor Appetite
- Excessive Hunger
- Difficult Chewing
- Difficult Swallowing
- Excessive Thirst
- Nausea
- Vomiting Blood
- Abdominal Pain
- Diarrhea
- Constipation
- Black Stool
- Bloody Stool
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble

NERVOUS SYSTEM

- Numbness
- Loss of Feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles Jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

CARDIO-VASCULAR/RESPIRATORY

- Chest Pain
- Pain over Heart
- Difficulty Breathing
- Persistent Cough
- Coughing Phlegm
- Coughing Blood
- Rapid Heartbeat
- Blood Pressure Problem
- Heart Problem
- Lung Problem
- Varicose Veins

EYE, EAR, NOSE AND THROAT

- Eye Strain
- Eye Inflammation
- Vision Problem
- Ear Pain
- Ear Noises
- Ear Discharge
- Hearing Loss
- Nose Pain
- Nose Bleeding
- Nose Discharge
- Difficulty Breathing Through Nose
- Sore Gums
- Dental Problems
- Sore Mouth
- Sore Throat
- Hoarseness
- Speech Problem
- Sinus Problems
- Allergies
- Jaw Pain

Describe Symptom (Circle):

- Pain _____
- Tender _____
- Numb _____
- Tingling _____
- Spasm _____
- Other _____

Using a scale of 1-10:

1 = Best / 10 = Worst
Indicate *your* overall level of discomfort: _____

Patient Signature: X _____

Doctor Signature: _____

-----↓----- **FOR DOCTOR USE ONLY** -----↓-----

| | | | | | |
|--------|-----------------------------|-------|-----------------------------|--------|-----------------------------|
| 353.0 | ___ Brachial Plexus Lesions | 724.8 | ___ Facet Syndrome | 756.12 | ___ Spondylolisthesis |
| 715.5 | ___ Osteoarthritis-Hip | 728.8 | ___ Cervical Myofascitis | 843.9 | ___ Hip or Thigh Sp/St |
| 720.2 | ___ Sacroilitis | 729.1 | ___ Myofascitis, Unspec. | 846.1 | ___ Sacroiliac Lig'mt Sp/St |
| 723.1 | ___ Cervicalgia | 729.2 | ___ Neuralgia, Unspec. | 846.8 | ___ Sacroiliac Sp/St |
| 723.4 | ___ Brachial Radiculitis | 737.3 | ___ Scoliosis | 847.0 | ___ Cervical Sp/St |
| 724.1 | ___ Thoracalgia | 739.0 | ___ Occipital/Cervical Dysf | 847.1 | ___ Thoracic Sp/St |
| 724.2 | ___ Lumbalgia | 739.1 | ___ Cervical Seg Dysf | 847.2 | ___ Lumbar Sp/St |
| 724.3 | ___ Sciatica | 739.2 | ___ Thoracic Seg Dysf | 847.3 | ___ Sacral Sp/St |
| 724.4 | ___ Lumbar Radiculitis | 739.3 | ___ Lumbar Seg Dysf | 847.4 | ___ Coccyx Sp/St |
| 724.4 | ___ Thoracic Radiculitis | 739.4 | ___ Sacroiliac Seg Dysf | Other | _____ |
| 724.79 | ___ Coccygodynia | 739.5 | ___ Pelvis/Hip Seg Dysf | | |

PREFERRED CHIROPRACTIC CENTER, P.C.

DR. ERIC SHAPIRO

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Charlotte, NC 28226

(704) 541-4747

Tax ID# 56-1992367

FINANCIAL POLICY

In order to provide quality chiropractic care, our office has established a financial policy related to payment for services rendered.

Insurance is an agreement between you and your insurance company, we are not a party to that contract. Our relationship is with you, not your insurance company. Our office staff will do their best to inform you of your particular plan benefits. However, it is ultimately the financial guarantor's responsibility to be aware of the plan's benefits. This is including, but not limited to, deductibles, copays, pre-certifications and referrals.

We will file insurance claims on your behalf. Any and all copayments/co-insurance amounts are due at the time services are rendered. Deductible amounts will be assigned to your account upon our notification of such amounts, payment of deductible amount will be due at that time. Patients with secondary insurance policies and/or health care reimbursement plans will be required to pay the copay/deductible of the primary insurance. Payments made by secondary carriers and/or health care reimbursement plans will be credited to your account upon our receipt of such payment(s).

Patients without insurance may pay an individual per visit fee or prepay for an office-determined number of visits (careplan) at a reduced fee. Careplans must be paid in full no later than the second visit or completed visits may be billed at the individual non-careplan per visit fee. Careplan refunds for unused visits are calculated by multiplying the number of visits used by the individual non-careplan per visit fee, then subtracting that amount from the prepaid careplan fee. Careplan visits can not be transferred to/from any account. Refunds for unused careplan visits must be requested by the patient. Payment is required at the time services are rendered.

Patients with workers' compensation and personal injury billing must notify our office of your injury claim at your initial visit, including insurance contact information. If you do not inform our office of your injury claim, the potential exists that we will not file claims on your behalf or provide assistance in legal matters. Any previous financial agreements are superseded when a legal injury claim occurs.

Our office policy is to collect self pay fees at the time services are rendered for any/all patient(s) arriving without current billing/insurance information.

Refunds of overpaid amounts are refunded after each of the guarantor's accounts are paid in full, and all insurance claims have been processed. Credit balances can not be transferred to other accounts.

A fee will be added to an account for which we receive a returned check. We reserve the right to affix a finance charge for all balances not paid in full by the last day of each month. Continual non-payment of an account may result in additional fees and/or legal action.

I understand that I am responsible for all fees associated with services rendered.

Patient Name (Print Please) _____

Guarantor's Signature _____ Date ____/____/____

By my signature, I indicate that I have read this policy, understand its content, agree to its provisions and am the party financially responsible for the above named patient.