Today's Date_____

Patient Name:_____

Who referred you to our office:_____

Date of Birth:_____/_____/_____ Age:_____ Gender:___

Address:_____City:_____ State:_____ Zip:_____

Cell Phone:_____ Home Phone:_____

Emergency Contact:_____ Phone:_____

Employer:_____
Email:_____

Have you ever had Chiropractic Care?:____Yes____No How long has it been?:___

Have you ever had Acupuncture?:____Yes____No How long has it been?:_____

Purpose or Reason for this appointment?:_____

Do you smoke?:_____ If so how much?: _____ Do you drink alcohol?: _____

Do you exercise?:____ How often?:_____ What type?: _____

Allergies:_____

Who is the guarantor of insurance coverage?:_____

Guarantor Date of Birth:_____

Have you ever suffered from or been diagnosed with or as having:

Y/N Broken Bones	Y/N Osteoarthritis	Y/N Depression
Y/N Rheumatoid Arthritis	Y/N High/Low Blood Pressure	Y/N Cancer
Y/N Diabetes	Y/N Strokes	Y/N Pacemaker
Y/N Circulatory Problems	Y/N Congenital Diseases	Y/N Drug Addiction
Y/N Pregnant	Y/N HIV	

DATE: _____

ACCT: _____

PATIENT: _____

PATIENT HISTORY

1. What is your **main complaint**? _____
2. On the scale below, please **circle** the **severity** of your **main complaint** (At it's worst)

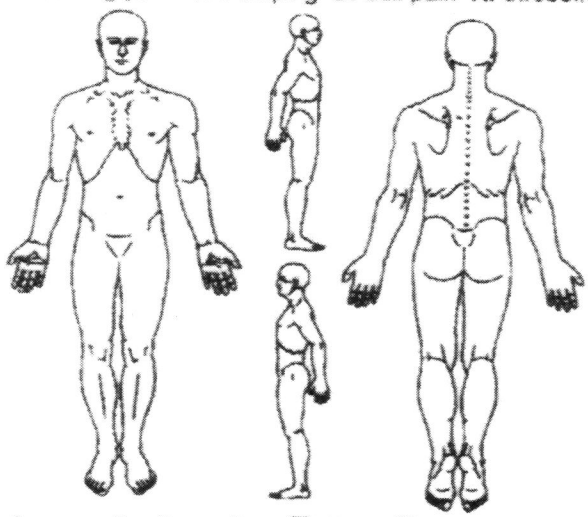
None		*Slight*		*Mild*		*Moderate*			*Severe*
1	2	3	4	5	6	7	8	9	10

3. On the scale below please **circle** the **percentage of time** you experience your **main complaint:**

	Occasional			*Intermittent*			*Frequent*			*Constant*	
0	10	20	30	40	50	60	70	80	90	100	%

4. How **long** have you been experiencing your **main complaint?** _____
5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ache **B:** burning pain **C:** cramping **D:** dull pain **R:** throbbing pain **N:** numbness **T:** tingling



6. When do you notice it most? ❑ AM ❑ PM
   How long does it last? _____Mins _____Hrs
7. What makes it feel better? _____
8. What makes it feel worse? _____
9. Have you ever had this problem in the past? ❑ Yes ❑ No
10. I have ❑ been hospitalized ❑ been treated by another chiropractor ❑ been treated by another specialty provider ❑ never received care for this problem.
11. Have you lost time from work because of it? ❑ Yes ❑ No
    Dates? _____ to _____
12. Are you Pregnant? ❑ Yes ❑ No
13. What was the first day of your last menstrual cycle? _____
14. Number of pregnancies? _____ Miscarriages? _____

Do you have **pain** and/or **difficulty** performing any of the following activities: (Check)

personal care ____
lifting ____
reading ____
concentrating ____
work ____
driving ____
sleeping ____
recreation ____
walking ____
sitting ____
standing ____
social life ____

Signature: _____

Date: ____/____/____

Today's Date_____

24Hour Appointment Cancellation Policy

Figa Healthcare, PLLC has a 24 hour cancellation/ rescheduling policy. If you miss your appointment, cancel, or change your appointment with less than 24 hours' notice, you will be charged $55 for a Chiropractic appointment and full price of a Massage appointment.

This policy is in place out of respect for our therapists and our patients. Cancellations with less than 24 hours' notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for Figa Healthcare, PLLC as described above. Thank you for your understanding and cooperation.

Limited Release of Medical Information

I authorize Figa Healthcare, PLLC to make inquiries and to release any pertinent information to any insurance company, adjuster, or attorney to facilitate collection under these assignments.

Conflict of Interest

Our Massage Therapists have been hired to help you in conjunction with treatment from Dr. Figa. They are not available to work on Patients privately outside of the office. If you would like to schedule more time with a particular Message Therapist, please call the office and we would be happy to place you on their schedule.

_____ _____

Printed Name Signature

Today's Date_____

WELCOME TO OUR OFFICE

We are committed to providing you the best care and are pleased to discuss our professional fees with you at anytime. Your clear understanding of our financial policy is important to our professional relationship. Please ask any questions you may have regarding our fees or your responsibility in complying with our financial policy and/or procedures.

- ❑ **Self Pay Patients**: Payment is due when services are rendered. We gladly accept MC, Visa, Discover, or check /cash.

- ❑ **Massage**: Please be aware, anyone failing to give 24 hour notice to cancel a massage appointment or failure to show for a massage appointment will be charged a $55 fee. (This applies to both Insurance and Self Pay Patients.)

- ❑ **Insurance Patients:** Professional services are rendered and charged to your insurance on your behalf. Any services not covered by your insurance are ultimately your responsibility and may have to be paid by you at the time of service. If you fail to keep your scheduled appointments or if you discontinue care for any reason other than discharge by the doctor, the bill is due and payable by you in full, immediately, regardless of any insurance claims submitted. Our office accepts billing for Individual or Group Insurance policies, Personal Injury claims, authorized Worker's Compensation and Medicare.

- ❑ **Collection/Attorney Fees:** I agree to pay all costs of a collection agency if necessary to obtain payment in the event legal action should become necessary to collect an unpaid balance due for medical services. I agree to pay reasonable attorney's fees or other such costs as the court determines proper.

Authorization to Process Drafts: I agree that Figa HealthCare PLLC shall be appointed as my agent to endorse drafts on any checks for payment of my bill for medical services rendered.

Limited Release of Medical Information: I authorize FigaHealthCare PLLC to make inquiries and to release any pertinent information to any insurance company, adjuster or attorney to facilitate collection under these assignments.

- ❑ **Assignment of Cause of Action:** In the event that any insurance company or other third party obligated to make payment to me or to FigaHealthCare PLLC for the charges made for the services, refuses to make such payment upon demand, I hereby assign, transfer and convey to Figa HealthCare PLLC any and all cause of action that might exist in my favor against any such company or person. I authorize Figa HealthCare PLLC to prosecute said action in my name or their name to collect fees due for care rendered and legal expenses, and to resolve said claims as they see fit.

- ❑ **HIPAA Policies and Procedures** I have read and understand the HIPAA Policies and Procedures for Figa Healthcare, PLLC.

Responsible Party Signature_____ Date:_____

Print Name_____

Figa HealthCare PLLC