

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

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## 24 Hour 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 \$20.**

This policy is in place out of respect for our therapists and our clients. 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.

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Printed Name

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Signature

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Date

## 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.

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Printed Name

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Signature

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### Price List

<b>New Patient includes Adjustment and Therapies and Dry Needling</b>	<b>\$90</b>
<b>Cash Adjustment or Cost when applying towards deductible: includes therapies and Dry Needling</b>	<b>\$55</b>
<b>Insurance visit *(COPAY depends on carrier and if Deductible is met) *</b>	<b>Varies</b>
<b>Some insurance EOB's take up to 2 months to receive, so please be aware</b>	
<b>Acupuncture full session</b>	<b>\$90</b>
<b>Dry Needling Therapy only</b>	<b>\$55</b>
<b>30 Minute Massage</b>	<b>\$35</b>
<b>60 Minute Massage</b>	<b>\$70</b>

**Soft Tissue Therapies, Dry Needle therapy, Graston (scraping), Cupping, E-Stim, Ultrasound, Ice and heat, decompression, and Cold Laser Therapy are included with price of adjustment**

**We carry various chemical free creams and ointments for pain and inflammation as well as pain patches and other supplements. Please ask if you have any questions.**

**Please Initial**

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