Patient Admittance Form

File #: _____

Full Name: _____ Date: _____

Address: _____ City/State/Zip: _____

Phone: (h)_____(c) _____(w) _____

Email: _____S.S.#: _____

DOB: _____Age: _____Marital Status: _____Spouse's Name: _____

Occupation: _____ Children (Ages): _____

Employer: _____ Employer Address: _____

How did you hear about our clinic? _____

Name of Personal Physician: _____

Emergency Contact: _____

Relationship: _____ Phone: _____ Address: _____

Accident – Injury Information

Are your present problems due to an accident/injury? _____ Date: _____

Type of accident/injury (check):

	Auto		On-the-Job		Sports		Military		Household		Slip & Fall		Personal

Insurance Information

Insurance Company: _____ Phone: _____

Agent: _____ Policy: _____ Group: _____

Insured's Name: _____ Insured's DOB: _____

Spouse's Name: _____ Spouse's Employer: _____

Spouse's Occupation: _____ Spouse's S.S.#: _____

Spouse's Insurance or other insurance you may use:

Insurance: _____ Phone: _____ Policy #: _____

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Treatment Authorization

I hereby authorize this office and its staff and doctors to examine and treat my condition as the doctors deem appropriate and I give authority for these procedures to be performed. I clearly understand and agree that all services rendered are charged directly to me and that I am responsible for payment of services by this office and all outside laboratory or radiology services performed on my behalf. Should collection of past due amounts become necessary, I will become responsible for all charges, fees and attorney fees.

Patient's Signature: _____ Date: _____

Consent to Treat a Minor

I (we) being the parents, guardian or custodian of the minor being _____, age _____, do hereby authorize, request, and direct this office, its doctors and staff to perform examinations, diagnostic X-rays, laboratory tests, and any treatment that in their judgment is deemed advisable or is requested while said minor child is under care of this office's doctors and staff until legal age. All charges for services and care given to said minor child will be charges directly to me (us) and I (we) will be personally responsible for payment for them.

Parent, Guardian or Custodian Signature: _____ Date: _____

Major Complaint

What is your major complaint? (Exact Description)

_____

_____

How long have you had this condition? _____ Have you had similar conditions in the past? _____

The condition is: (check one)

	Worse		Same		Better		Consistent		Recurring

How does this condition interfere with your work or daily routine? _____

When is your condition worse? (check one)

	Morning		Afternoon		Evening		Night

What aggravates your condition? _____

What relieves your condition? _____

Names of other doctors/hospital seen for this condition: _____

Previous diagnosis for the condition: _____

Type of previous treatment and/or surgery for this condition: _____

Results of previous treatment: (check one)

	Good		Fair		Poor		Other

Surgeries:

Year: _____ Reason _____ Hospital _____

Year: _____ Reason _____ Hospital _____

List any serious illness or medical problems that other doctors have diagnosed: _____

_____

_____

Are you a smoker? Yes or No Are you pregnant? Yes or No Any Allergies? Yes or No

Medications you are presently taking:

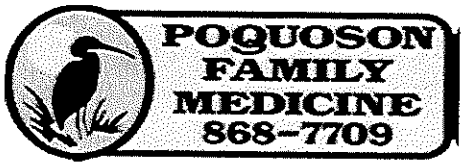
_____ _____

_____ _____

_____ _____

Previous Health Problems (circle any of the following you have had or presently have):

Aneurysm
Arch support
Arm pain
Arthritis
Asthma
Bed wetting
Birth complications
Birth defects
Cancer
Cervical whiplash
Concussion
Convulsions
Cyst
Diabetes
Dislocation
Dizziness
Ear infections
Electronic implant
Fainting
Fractured Bones
Headaches
Heel lifts
High blood pressure
Joint replacement
Kidney stones
Knocked unconscious
Leg pain
Low back pain
Memory lapse
Metal screws/implants
Midback pain/stiffness
Neck pain/stiffness
Osteoporosis
Pacemaker
Pinched Nerve
Ruptured spinal disc
Scoliosis
Seizures
Slipped spinal disc
Spinal curvature
Spinal injections
Spinal surgery
Spinal taps
Stroke
Tumor



POQUOSON FAMILY MEDICINE & CHIROPRACTIC CLINIC

PATIENT RESPONSIBILITY & FINANCIAL AGREEMENT

1. **FINANCIAL RESPONSIBILITY:** I assign any benefits to PFM that I may have for reimbursement for my medical treatment received by PFM which I may be entitled to from any insurance coverage, worker's compensation benefits, disability benefits, and all settlements, judgments and verdicts against any liable third party. If I fail to pay my outstanding PFM balance, I understand PFM will have a lien against any such settlement, judgment or verdict equal to the full amount of any unpaid PFM bill. I further direct any attorney handling or disbursing such proceeds to withhold and promptly pay PFM the full amount of any outstanding balance owed by me, the Patient, to PFM for medical services rendered. I also understand and agree to pay a $30 fee incurred for any returned checks.

2. **ALL PAYMENTS DUE AT TIME OF SERVICE:** While PFM as a courtesy to patients will bill most insurance companies; PFM is under no obligation do so. If your insurance company fails to pay all or part of your bill, you are responsible for all charges. By signing this agreement, I agree to accept full responsibility of all PFM charges. Full payment is required at the time of service unless other arrangements are made. If any PFM bill is not paid in full at the time of the service, PFM reserves the right to charge interest at a rate of 12% from the time of delinquency on any outstanding balance. In addition to interest, I agree to pay both any reasonable collection agency and/or attorney fees associated with recovering any outstanding balance. Copays are due at check in.

3. **DISCLOSURE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS:** I authorize PFM to share my medical information and medical records to my insurance company and third party payers. I also assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

4. **PATIENT/FAMILY CONDUCT:** While in the office of PFM, I agree to be respectful and courteous to the PFM Staff, all medical providers and other patients. I realize the importance of honoring my scheduled appointments and agree to provide adequate notice (at least 24 hours) for rescheduling appointments. Failure to keep appointments or rescheduling without adequate notice may result in consequences including a charge of $50.00 for missed appointments. Repeated cancellations may result in discharge from the practice. If you need to be seen the same day please contact PFM for "same day" availability accommodations.

5. **PFM IS NOT RESPONSIBLE FOR LOSS OF PERSONAL ITEMS:** PFM will not be responsible for any loss, theft or damage to any personal property of the Patient (including money, jewelry, documents, clothing, spectacles, dentures, prosthetic devices or other personal articles).

6. **PATIENT CARE:** PFM provides medicinal and holistic approaches to healing. All medications (OTC and Rx) will be monitored regularly and will require previous medical records (if available) to obtain prescription(s). Please note that pain management cases will be referred to the appropriate pain management facility. Please allow 72 hours for all prescription refills. For accurate records and treatment purposes, it is the Patient's responsibility to provide PFM physicians with the most updated/current medicines taken by the Patient

EACH PARTY TO THIS AGREEMENT ACKNOWLEDGES THAT THEY HAVE READ AND FULLY UNDERSTAND THE MEANING AND CONSEQUENCES OF EACH AND EVERY TERM AND PROVISION OF THIS AGREEMENT

Print Patient's Name_____ Date of Birth_____ Date & Time_____

Patient or Responsible Party Signature Relationship to Patient_____