Dr. William Bucur—16995 W Greenway Rd. Suite 102/Surprise, Az 85388/623-433-8895

# CHIROPRACTIC REGISTRATION

**HOW DID YOU HEAR ABOUT OUR OFFICE?** **Please Circle One.**

**Community Event, Mailing, Door Hanger, Internet, Patient Referral - Name: _____**

**Other: _____**

| Patient First Name & Nickname (if applicable): | Middle Initial: | Last Name: |
|---|---|---|
| | | |

| Address: | City: | State: | Zip: | Home Phone: |
|---|---|---|---|---|
| | | | | |

| Cell Phone: | Cell Carrier: | Email: | Birth Date: / / | Sex: | SSN: |
|---|---|---|---|---|---|
| | | | | | |

**Employment Status:**

**Full Time Part Time Retired Unemployed Student**

| Occupation: | Employer: | Yrs. Worked: | Phone: | Ext: |
|---|---|---|---|---|
| | | | | |

| Address: | City: | State: | Zip: |
|---|---|---|---|
| | | | |

| Spouse's Name: | Spouse's Date of Birth: | Spouse's SSN: |
|---|---|---|
| | | |

**INSURANCE Information – Patient Relationship to Insured:**

**( ) Self ( ) Spouse ( ) Dependent**

**Name of Primary Policy Holder: _____**

**Insurance Company Name: _____**

**Insurance Policy Number: _____**

**Please check if you object to receiving any of the following:**

**Monthly office newsletter _____ Happy Birthday card _____ Any Other mailings _____**

**PARENT OR GUARDIAN OF MINOR (under 18 yrs)Person Responsible For Payment**

| First | Middle | Last |
|---|---|---|
| | | |

| Address: | City: | State: | Zip: |
|---|---|---|---|
| | | | |

| SSN#: | Birth Date: | Phone: |
|---|---|---|
| | | |

**I VERIFY AND ACKNOWLEDGE THAT ALL INFORMATION IS CURRENT AND CORRECT (PLEASE SIGN BELOW).**

| Patient Signature or Parent/Guardian: | Date: |
|---|---|
| | |

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## HEALTH HISTORY

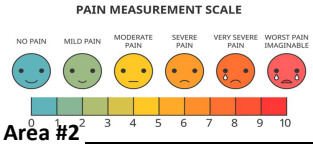
**REASON FOR CONSULTING OUR OFFICE (circle all that apply)**

Wellness Corrective Care Symptomatic Relief Undecided Auto Accident Workers Compensation Injury Personal Injury

Date of Injury/Accident/Condition: _____

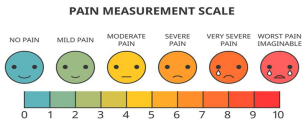
**DESCRIBE AREA OF COMPLAINT - Begin with the area causing the most distress. (circle the words that appy)**

**Area #1** _____ **Tone - (Circle) - Dull Sharp Achy/Soreness Stiff/Tightness Numbness/Tingling**



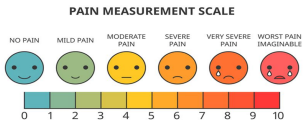

**Rate - _____ Frequency – (Circle) - Constant Intermittent Occasional**

**Area #2** _____ **Tone - (Circle) - Dull Sharp Achy/Soreness Stiff/Tightness Numbness/Tingling**



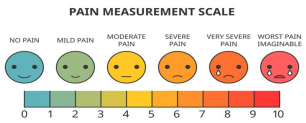

**Rate - _____ Frequency – (Circle) - Constant Intermittent Occasional**

**Area #3** _____ **Tone - (Circle) - Dull Sharp Achy/Soreness Stiff/Tightness Numbness/Tingling**




**Rate - _____ Frequency – (Circle) - Constant Intermittent Occasional**

**Area #4** _____ **Tone - (Circle) - Dull Sharp Achy/Soreness Stiff/Tightness Numbness/Tingling**




**Rate - _____ Frequency – (Circle) - Constant Intermittent Occasional**

1. Have you tried anything to relieve the pain? If so, what? _____ Results: **Yes No**

2. Have you seen any other doctors for this condition? If yes, who? _____ Results: **Yes No**

3. Are you currently under drug/medical care? **Yes No** Condition _____ Results: **Yes No**

4. Previous Chiropractic Care: _____ Approx. date of last visit: _____/_____/_____

5. Previous Spinal Injuries? **YES NO** _____ Automobile Accidents? **YES NO**

6. How many & when _____ Exercise Problems or Injuries? **YES NO**

7. Exercise**:** **Often Occasionally** 8. Difficulty Sleeping? **YES NO** 9. Position that Relieves Tension? **Side Stomach Back**

10. Previous Injuries or Broken Bones: _____

11. Surgeries: When:_____Area:_____

**Please circle all that apply to you: (cont. on next page)**

| | | | |
|---|---|---|---|
| Allergies | Arthritis | Asthma | Blood Clots |
| Blood Pressure | Cholesterol | Chronic Pain | Depression |
| Diabetes | Digestion Issues | Eczema | Epilepsy |
| Hearing & Ear | Heart Disease | Heart Attack | HIV/AIDS |
| Hepatitis (A, B, C) | Infectious Disease | Joint Replacements | Lung Conditions |
| Menopause | Mental Health | Migraine | Neurological Issues |
| Shingles | Sleep Disorder | Thyroid | Other:_____ |

Pregnancy: Due Date:_____ # of weeks: _____

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**My initials indicate that I have read and agree with each item below.**

**Professional Fees**

Any co-payment or co-insurance will be due in full at the time of service.

All initial appointment fees are due upon first day of service. Special financial arrangements must be discussed by the second appointment.

A $25 processing fee will be charged for any NSF fees on any return of payment.

A $25 fee will be charged for missed appointments (no show/no call) , $ 10 fee for canceled appointments with less than 24 hour notice, if rescheduled at time of cancellation fee will be waived.. This includes Auto cases. All payments will be processed to the credit card on file the same day. All fees will be donated to Kentucky Anna Children's Hospital.

**Authorization of Release of Records**

I authorize the release of any medical information necessary to process my claim and/or for better treatment in this office including x-rays, MRIs, Lab tests, etc.

**Payment and Assignments of Services**

It is my responsibility to know what services are covered by my insurance plan. I have reviewed carefully the section in my insurance coverage booklet that describes the coverage of benefits for the services that will be provided at this office. I will call my plan administrator with any questions. I will pay for any services I receive that are not covered or denied by my insurance plan.

I will provide full and accurate insurance information in advance of my appointment, or will pay for the appointment on a self-pay basis. I will present my insurance card at the time of my appointment. I will provide updated insurance information promptly in the case of any changes.

I understand that I, not my insurance company, am responsible for full payment of my fees. I understand that insurance billing is provided by my healthcare provider as a courtesy, but I remain the responsible party.

I understand that, all reimbursements paid to me will be promptly forwarded (within 10 days) to Greenway Cotton Chiropractic to be applied to my charges in arrears.

I understand that, if after 90 days my insurance company has not responded I will receive a statement. I agree to pay my balance in full at that time. I understand that I will be reimbursed promptly if and when the insurance payment arrives.

I understand that, if my account is referred to a collection specialist due to nonpayment, I will pay any applicable collection fees.

I understand that, "Authorization to Pay the Doctor" I hereby authorize payment directly to Greenway/Cotton Chiropractic of the insurance benefits otherwise payable to me.

I understand that, Personal Injury/Auto Claim_____ Non Personal Injury/Auto Claim _____ in the case that I choose Non Personal Injury/Auto Claim, I state that I was not involved in any auto accident or personal injury caused by any other party. I further state that my diagnostic test or treatment is not the result of an injury while on the job or by any other person related to my employment.

I understand that, In the case of auto carrier or workman's compensation claims, whether settled or unsettled, I understand that I am responsible for all costs of chiropractic care which become payable within 30 days after the end of treatment and am held to the same rules as mentioned in the balance held policy noted above.

I understand that I am solely responsible for any and all missed, canceled or reschedule appointment fees whether the charges are in relation to an auto case or otherwise. I understand that my credit card will be charged at the time of the occurrence, if I am unable to give proper notice of more than 24 hours prior to my schedule appointment.

**Dispute Procedure**

In the event of a dispute between myself and Greenway/Cotton Chiropractic whether for charges, procedures or balances I owe, I hereby waive the statute of limitations on collections and/or recovery. I also understand that litigation is certain once balances owed reaches 120 days past due, and I agree to pay all litigation costs incurred by Greenway/Cotton Chiropractic as a result of inaction to timely payment of my account. I understand and agree to pay a 50% collection fee on any outstanding balances due that are turned over to a collection agency.

**By signing this document, I hereby agree to abide by all mentioned policies, authorizations, assignments, and procedures.**

**Print Patient Name:** _____

**Signature of Patient:** _____ **Date:** _____

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## HIPPA Privacy Rule: Consent for Purposes of Treatment, Payment and Healthcare Operations

**I acknowledge that Greenway/Cotton Chiropractic "Notice of Privacy Practices Abridged Edition" has been provided to me.**

**I understand I have a right to review the entire Greenway/Cotton Chiropractic Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Greenway/Cotton Chiropractic. The Notice of Privacy Practices for Greenway/Cotton Chiropractic also, is provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Greenway/Cotton Chiropractic duties with respect to my protected health information.**

**Greenway/Cotton Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.**

**PATIENT ACKNOWLEDGEMENT**

**By signing my name below, I acknowledge receipt of the above stated notice and my understanding and agreement to its terms.**

_____ _____

**Signature of Patient or Personal Representative** **Date**

_____

**Print Name of Patient or Personal Representative**

_____

**Description of Personal Representative's Authority**

## Informed Consent to Chiropractic Services

**I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the licensed doctor of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.**

**I consent to the opportunity to discuss with the doctor of chiropractic or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.**

**I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.**

**I have read, or have had read to me, the above consent. I consent to the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.**

**Patient Signature**_____ **Date** _____

**Witness/ Personnel:** _____**Date:** _____