Affiliated Chiropractic

2250 E Postal Road #4
Pahrump, NV 89048
775-727-8900 ~ 775-727-9452 fax

Affiliated Physical Therapy

Name: _____ DOB: _____Age: _____ Sex: _____

Street Address: _____

City:_____ State:_____ Zip: _____ Home Phone: _____

Cell: _____ Social Security #:_____

Primary Insurance: _____ Secondary Insurance: _____

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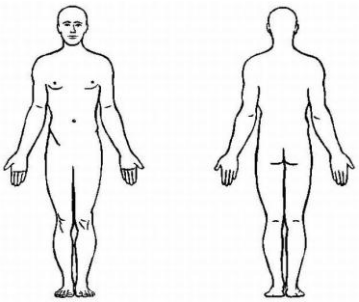
1. Indicate on the drawings below where you have pain/symptoms.



2. How would you describe the type of pain?
   - ○ Sharp
   - ○ Dull
   - ○ Achy
   - ○ Burning
   - ○ Shooting
   - ○ Stiff
   - ○ Numb
   - ○ Other: _____

3. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
   1 2 3 4 5 6 7 8 9 10

4. How long have you had this problem? _____
6. How do you think the problem began? _____
7. What aggravates your problem? _____
8. List all of the prescription medications you are currently taking?

   _____

9. List all of the over-the-counter medications you are currently taking?

   _____

   _____

10. List all of the relevant surgical procedures you have had.

    _____

    _____

11. What activities do you do outside of work?

    _____

    _____

12. Are you pregnant? **YES / NO** Due date: _____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

_____ _____

Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
You May Refuse to Sign This Acknowledgement

I have reviewed a copy of Affiliated Chiropractic and/or Affiliated Physical Therapy's Privacy Practices.

CANCELLATION AND NO SHOW POLICY

I agree to the following stipulations for 50 minute massage:

1. Cancellations **without 24** hr notice will result in **a $25 Cancellation fee**
2. If a fee has been applied to your account **NO FUTURE MASSAGES** will be scheduled until payment is made in full
3. If you "no show" for **2 or more** massages you will not be permitted to schedule massages for **2 months**
4. If you are more than **15 minutes** late for your massage you will e required to reschedule your massage and **may be subject to a fee**

CONSENT FOR CARE AND TREATMENT OF MINOR

I, the undersigned, do hereby agree and give my consent for Affiliated Chiropractic and/or Affiliated Physical Therapy to furnish medical care and treatment to _____ as considered necessary and proper in diagnosing or treating his/her physical and mental condition.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, the undersigned, do hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to Affiliated Chiropractic and/or Affiliated Physical Therapy. A photocopy of the assignment is to be considered as valid as the original. I, the undersigned, do hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

_____ _____

Signature Date

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered unless prior arrangements have been made. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 120 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit to Affiliated Chiropractic and/or Affiliated Physical Therapy.

The above does not apply for those patients that are treated under Worker's Compensation and Attorney Liens. However, be advised that if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

If I fail to make any payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

The above information has been read and explained to me.
I UNDERSTAND IT IS MY FULL RESPONSIBILITY FOR PAYMENT OF MY ACCOUNT IN THE EVENT MY INSURANCE DOES NOT PAY.

_____ _____

Signature Date

_____ _____

Affiliated Chiropractic and/or Affiliated Physical Therapy Representative Date