Avdic
PAIN & REHAB CLINIC

3193 Lemay Ferry Road
Saint Louis, MO 63125
(314)487-8900

PERSONAL INFORMATION

First Name: _____ Last Name: _____ MI: ____ Date: _____

Address: _____ City/State/Zip: _____

Home Ph: _____ Cell Ph: _____

Email Address: _____

Birth Date: _____ Social Security #: _____Gender: ☐M ☐F

Occupation:_____Employer:_____

Preferred Language_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Spouse's Name: _____Number of Children: _____

Race: ☐White ☐African American ☐Asian ☐Hawaiian / Pacific Islander
☐American Indian/Alaskan ☐Hispanic / Latino ☐Other_____
☐I do not wish to specify

How did you hear about our office? _____

Primary Care Physician: _____ Phone Number: _____

Have you seen a Chiropractor before? ☐Yes ☐No

If Yes, Who? _____ Phone #: _____

Emergency Contact:

Name: _____Relation: _____Phone #: _____

INSURANCE AND BILLING INFORMATION

Person ultimately responsible for account: ☐Self ☐Other

If other: Name: _____ DOB: _____ Relation: _____

_____(INITIALS) I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company.

Print Name: _____Sign: _____Date_____

REASON FOR VISIT

What is/are your complaints? _____

When did these symptoms begin (most recent episode)?: _____

How did the symptoms begin: ☐Auto Accident ☐Work Accident ☐Fall

Please explain how accident happened: _____

_____

_____

Is this condition interfering with your: ☐Work ☐Sleep ☐Daily Routine

Other (please explain): _____

How often do you experience your symptoms?

☐Constantly (75%-100% of the day) ☐Frequently (50%-75% of the day)

☐Occasionally (25%-50% of the day) ☐Intermittently (0%-25% of the day)

Since your symptoms began, have they been:

☐Getting Worse ☐Getting Better ☐No Change

Have you seen any other healthcare professionals for this condition? ☐Yes ☐No

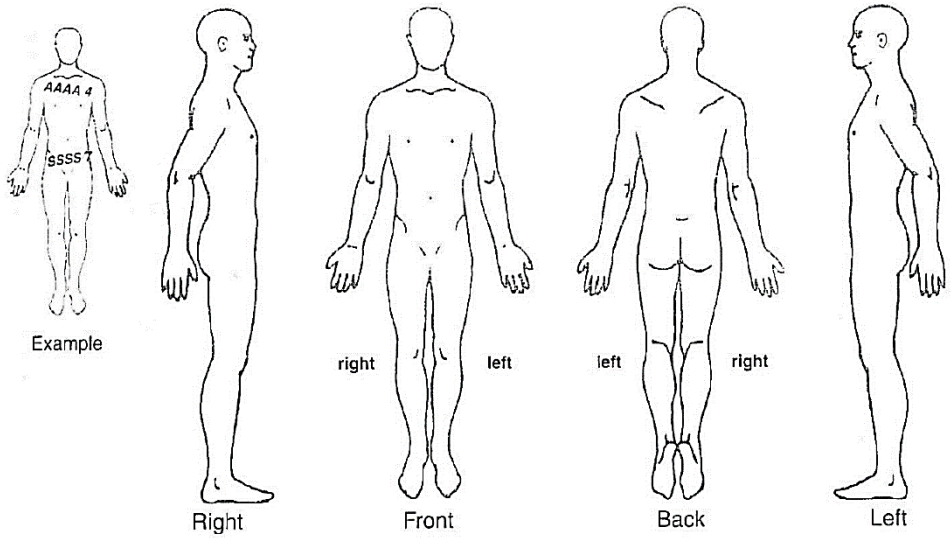
If so, Who? _____ Phone Number: _____

What treatment did you receive? _____

Were X-rays/MRI/Tests etc. performed? ☐Yes ☐No If So, Where? _____

Please mark all areas of pain with the appropriate symbol and indicate the degree of pain using a scale of 1 (mild discomfort) to 10 (unbearable).

Description:	Numbness	Pins & Needles	Burning	Aching	Stabbing/Sharp
Symbol:	NNNN	PPPP	BBBB	AAAA	SSSS



Print Name: _____Sign: _____Date_____

MEDICAL HISTORY

Do you currently or have you had in the past any of the following (Please check):

☐ Heart Attack	☐ Neck Pain	☐ Alcohol/Drug Abuse
☐ Stroke	☐ Back Pain	☐ HIV / AIDS
☐ Congenital Heart Defect	☐ Headaches	☐ Psychiatric Problems
☐ High / Low Blood Pressure	☐ Kidney Problems	☐ Difficulty Breathing
☐ Heart Murmur	☐ Liver Problems	☐ Cancer
☐ Fainting/Seizures/Epilepsy	☐ Hepatitis	☐ Ulcers / Colitis
☐ Diabetes	☐ Venereal Disease	☐ Asthma
☐ Pacemaker	☐ Shingles	☐ Arthritis
☐ Birth Defects	☐ Sinus Problems	☐ Artificial Bones/Joints

Please list any other serious medical conditions you have had or provide explanation for above: _____

_____

Are you taking any medications? ☐ Yes ☐ No

If Yes, Please List: _____

_____

_____

Do you have any allergies? ☐ Yes ☐ No

If Yes, Please List: _____

_____

Please list any previous surgeries: _____

_____

Please list any past accidents/falls/trauma with dates: _____

_____

Family health history (i.e. cancer, anemia, diabetes, high/low blood pressure):

_____

Do you exercise? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No How Much? _____ For how long: _____

For women: Are you pregnant? ☐ Yes ☐ No Yes/How Long? _____

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 to the information I have provided.

Print Name: _____Sign: _____Date_____

OFFICE POLICIES

_____1. **This office will file insurance claims for you**. As a courtesy, this office will obtain a verification of applicable insurance benefits as they are quoted to us, but some third-party payers misquote benefits, coverage, and liability. Our office and staff are not responsible for what a third-party payer and/or representative may tell us. Any contractual, written, verbal or other arrangements between you and an attorney, insurance company, liable or third-party payer are between you and said party.

_____2. **Payment is due at time of service**. Including copays, co-insurance, deductibles, and all non-covered charges. Due to the variations among insurance companies, we will estimate your portion to the best of our ability. Any balances due will be expected at the time of billing.

_____3. **Patients are responsible for charges on all services and/or products, which may exceed the maximum allowable**.

_____4. **All account balances must be paid in full within 90 days**. Patients are fully responsible for all money owed and such payment is not contingent on any settlement, claim, judgment, or verdict by which patient may eventually recover said fees and is also regardless of any attorney liens or pending settlements.

Assignee is fully responsible to this office for any and all treatment, products, and services rendered to the patient or minor.

_____5. **Personal Injury** (car accidents) Our office will bill you Medpay first, second option is to bill your attorney, last option is to bill your health insurance. Please note that if we bill your health insurance, you are responsible for any co-pay, co-insurance or deductible on date of service and you will be responsible for the full amount billed in case that you do not have accidental insurance on your policy.

_____6. **Any balance past 90 days due may be submitted to an attorney and/or collection agency for legal collection**. For which the undersigned agrees to be 100% responsible for all monthly service charges, interest, and costs related to, but not limited to, all collection related expenses, attorney, court, and filing fees.

_____7. **Returned checks, debit, and credit charges due to insufficient funds, stopped payments, or other reasons of non-payment will be assessed a $30 charge**.

_____8. **Missed appointment fees** are charged without 24-hour notice of cancellation. The missed appointment fees will only be forgiven in the case of an emergency and only considered after the second missed appointment. The following fee schedule applies:

1st cancellation: $10 charge;

2nd cancellation: $20 charge;

3rd and subsequent cancellations: $30.

Print Name: _____Sign: _____Date_____

INFORMED CONSENT, BENEFITS, RISKS & TREATMENT OPTIONS

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various physical therapies on me (or the patient for whom I am legally responsible) by licensed doctors and staff of Avdic Pain and Rehab Clinic who now or in the future are employed by the office above. I have had an opportunity to discuss with the Doctor of Chiropractic the nature and purpose of chiropractic adjustments and other procedures.

I understand that prior to establishing a treatment plan the doctor must perform an examination in order to determine the exact cause of the complaint. During this examination the doctor will perform some procedures intended to reproduce your symptoms, which will allow for better understanding of the nature of your condition. There is a possibility that this exam may temporarily aggravate your symptoms. I also understand that results are not guaranteed. All patient care, including chiropractic care, has the potential for adverse effects.

I understand that the risks associated with chiropractic care include, but are not limited to fractures, disc injuries, strokes, dislocations and sprains; however, these side effects are extremely rare. The most common side effect following examination and/or treatment is muscle soreness. 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 treatment and/or procedure, based upon the facts known to him/her. Some chiropractic adjustments may cause a “popping” sound, which is related to a gas and fluid exchange between the joint surfaces.

In addition to chiropractic care, there may be other treatment options for your condition. These may include: self-administered care (i.e. over-the-counter analgesics, rest, ice, etc.), medical care & prescription drugs, physiotherapy, hospitalization, and/or surgery. If you choose to use one the aforementioned “other treatment” options, you should be aware that there are risks of such options and you may want to discuss these with your primary care physician.

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

Print Name: _____Sign: _____Date_____