NEW PATIENT REGISTRATION

Please fill out this form so we can know you better!

LOMBARDO CHIROPRACTIC

PERSONAL INFO

PATIENT NAME		DOB	Appt Date & Time
Local Mailling Address		SSN	
City/State/Zip Code		Home Phone #	
Email Address		Cell Phone #	
Preferred method of contact Home Cell Email		Sex M F	Marital Stat M D S W
Employed? No Full Part Self Retired		Occupation	
Is your condition the result of an accident? Yes No		PCP/Family Doctor	Permission to contact? Y N
Emergency Contact Relationship Phone #		Permission to advise of medical status? Yes No Relationship Phone #	INITIAL

MINOR

IF THE PATIENT IS A MINOR, PLEASE FILL OUT THE FOLLOWING INFORMATION: A minor is defined as any patient who is under the age of 18. The person bringing the minor in to the appointments is responsible for the account, regardless of custody and/or insurance policy holder information. Therapies conducted in a closed room (e.g. Massage) by anyone other than the Doctor may NOT be conducted without the presence of a supervising parent or guardian.

Responsible Adult Name		DOB	SSN
Relationship		DL #	
Address (if different)		Mother's Name	Phone #
City/State/Zip Code		Father's Name	Phone #

AUTHORIZATION

AUTHORIZATION: I hereby authorize release of any medical information necessary to process all claims to the insurance company. I authorize payment of any medical benefits submitted for my claims to be paid directly to this office. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

SIGNATURE	DATE
PRINTED NAME	RELATIONSHIP TO PATIENT

VITALS

OFFICE USE ONLY:

HEIGHT	WEIGHT	BP	TEMP	DOMINANCE R L

LCC POLICIES

Please read each item before initialling

LOMBARDO CHIROPRACTIC

HIPAA POLICY

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them (or declined the opportunity to read them). A digital copy can be downoaded from *www.lombardochiro.com/forms* . I understand the Notice of Privacy Practices, and this form will be placed in my patient chart and maintained for six years.

INITIAL

PAYMENT POLICY

Lombardo Chiropractic Clinic accepts cash, personal checks, VISA, Master Card, Discover, and Care Credit. We do not accept American Express. Only in-state checks are accepted, and there is a $20 service charge for returned checks. We participate in the Preferred Chiropractic Doctors (PCD) medical discount plan which can save the patient more than 25% on charges that cannot be billed to insurance. By law, we cannot apply this discount to any charges which may be filed with any type of insurance. Purchases of pillows, cushions, supplies, and/or supplements are non-returnable unless defective from the manufacturer. There is a $35.00 non-billable fee in addition to the cost of services rendered for seeing a Doctor outside of normal business hours.

Payment is required at the time services are rendered; this includes applicable coinsurance and copayments for participating insurance companies, as well as any services or supplies not covered by insurance. We bill participating insurance companies as a courtesy, patients are responsible to make sure all charges are ultimately paid. Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments.

If there is an unpaid balance without payment arrangements, the account may be placed with an external collection agency. Patient will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees during collection efforts.

INITIAL

CANCELLATION/NO SHOW POLICY

Except for in the case of an emergency, if an appointment is not cancelled at least 24 hours in advance there is a $25 fee; this fee will not be covered by insurance. If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment, and the $25 fee will be applied.

INITIAL

CONSENT FOR TREATMENT

Your Doctor of Chiropractic will use the Activator instrument to perform the spinal manipulative therapy as the primary treatment for your condition. Other treatments may include but are not limited to: Electro-therapy (attended or unattended), Ultrasound, Therapeutic Exercise, Manual therapy, Massage therapy, and Cold Laser therapy. The Doctor may perform any or all of the following tests during evaluation: Neurological, Orthopedic, Range of Motion, and Muscle Strength testing.

As with any healthcare procedure, there are certain complications which may arise during the administration of any treatment or therapy. Complications are rare, including (but not limited to): stiffness, soreness, increased pain fracture, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. There is disagreement about some types of manipulation of the neck being associated with injuries to the arteries which, in exceedingly rare instances, may contribute to serious complications including stroke. Every reasonable effort will be made to screen for contraindications to care, however, if you have a condition that would otherwise not come to the Doctor's attention, it is your responsibility to inform them.

By signing below, I understand the above explanation of the initial examination and chiropractic related treatments. I give my consent to the examination and treatment. Having been informed of the risks involved in undergoing treatment and have decided that it is in my best interest to continue as recommended. I hereby give my consent to examination and treatment (which includes spinal manipulation and/or therapy) as directed by my Doctor of Chiropractic.

Print Patient's Name	Patient/Guardian's Signature	Date
Print Witness Name	Witness Signature	Date