TROPICANA WEST CHIROPRACTIC

Revised 05/2018

PATIENT INFORMATION

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink, leaving nothing blank. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name_____ D.O.B: ___/___/____Age ___SS #___-___-____
Last First Middle Initial

Gender: ☐ Female ☐ Male E-mail Address_____

Do you wish to receive educational Chiropractic information via email? ☐Yes ☐No

Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____Zip _____

Cell Phone (____)_____Home Phone (____)_____Work Phone (____)_____

Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ Separated ☐ Divorced ☐ Minor

Patient Employer/School _____ Occupation _____

Spouse or parent's name _____ Employer _____ Phone (___)_____

Person to Contact in case of Emergency _____Phone (___)_____

How did you hear about our office? Internet Phone Book Location Insurance Patient Relative

Who? _____

INSURANCE INFORMATION

Check this box if you do not have health insurance ☐

Insurance Co. _____ ID # _____ Phone (___)_____

Name of insured _____ Relationship to patient_____

Birthday _____ Social Security # ____-___-____

Do you have additional Insurance? ☐ *No* ☐ *Yes* ***if yes, Please Complete the Following:***

Insurance Co. _____ ID # _____ Phone (___) _____

Name of insured _____ Relationship to patient_____

Birthday _____ Social Security # ____-___-____

HISTORY

Have you been treated by a chiropractic physician before? ☐ Yes ☐ No

If Yes Doctor's name _____ Date of last office visit ____/____/____

Are you under another doctor's care for anything now? ☐ Yes ☐ No

If yes, list doctor's name and problem_____

Are you currently taking any over-the-counter or prescription medications? ☐ Yes ☐ No

If yes, please list _____

Please list any and all surgeries you have had in your lifetime (whether or not they are related to your back) and what year they were performed? _____

_____

If you answer yes to the following 3 questions, please indicate the month and year in which it happened.

Have you been in any recent **car accidents** (driver or passenger)? ☐ Yes ☐ No When? ____/____/____

Have you had any **work injuries**? ☐ Yes ☐ No When? ____/____/____

Have you had any **traumas, like fractures or falls**? ☐ Yes ☐ No When? ____/____/____

Is there anyone in your *family or yourself* with:

Cancer? ☐ Yes ☐ No Who? _____ Diabetes? ☐ Yes ☐ No Who?_____

Heart Disease? ☐ Yes ☐ No Who? _____ Arthritis? ☐ Yes ☐ No Who? _____

Spinal Problems? ☐ Yes ☐ No Who? _____ Scoliosis? ☐ Yes ☐ No Who? _____

TROPICANA WEST CHIROPRACTIC

SYMPTOMS

What is your **primary complaint**? _____

What are your goals with Chiropractic Care? _____

_____

What is your condition due to? ☐ Auto Accident ☐ Work Injury ☐ Unknown ☐ Other _____

When did your symptoms appear? _____

Have you **had these symptoms before?** ☐ Yes ☐ No if Yes When? _____

Are your symptoms: ☐ Improving ☐ Getting Worse ☐ Staying about the Same ☐ Coming and Going

Rate the severity of your pain on a scale from *1 (least pain) to 10 (severe pain)*_____

Circle Type of Pain: Sharp Dull Throbbing Numbness Aching Shooting

Burning Tingling Cramps Stiffness Swelling Other _____

What activity(s) **aggravate** your condition: ☐ Standing ☐ Walking ☐ Sitting ☐ Bending ☐ Twisting

☐ Lifting ☐ Lying ☐ Coughing ☐ Other _____

What activity(s) **alleviate** your condition: ☐ Standing ☐ Sitting ☐ Resting ☐ Ice/Heat ☐ Walking

☐ Lying ☐ Stretching ☐ Other _____ ☐ None

Does it **interfere** with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Other Doctor(s) seen for **this condition**: Chiropractor M.D. Osteopath Orthopedic Neurologist

Acupuncturist Podiatrist Dentist Other _____

Doctor's Name _____ Date Last Consulted ____/____/____

Tests Performed: ☐ MRI ☐ CAT scan ☐ X-ray ☐ Blood ☐ Urinalysis **Where?**_____

Are you Pregnant? ☐Yes ☐ No ☐ Unsure Estimated Date of Last Menstruation ____/____

Please draw the appropriate symbols on the figures to show where and what kind of pain or problem you are experiencing.

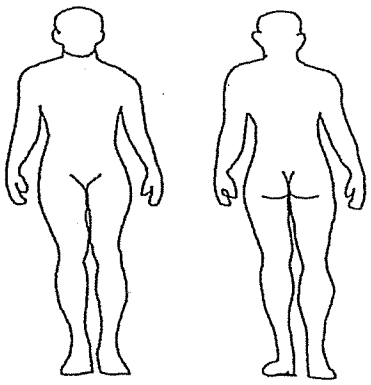
Aching
^^^^^^

Burning
XXXXX

Numbness
- - - - - -

Pins & Needles
0000000

Stabbing
/ / / / / / /



Please Circle the complaints that apply

Loss of sleep Dizziness Ear Noise

Headaches Muscle Spasms

To the best of my knowledge the information given on this form is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in medical, personal, legal, or insurance status.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Printed Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

TROPICANA WEST CHIROPRACTIC
EHR Certification Information

NAME:_____ **DATE:**_____

Do you wish to receive appointment notifications through E-mail and/or Text messages?

- ☐ Opt In for **Email Notifications and text reminders**
- ☐ **Email Appointment** reminders only
- ☐ Opt In for **Text appointment reminders**

**Dear Patient: Due to Federal Regulations, the United States Government is now requiring that we supply them with the following information.*

ETHNICITY:

- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Latino

RACE:

Please check all that apply:

- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ Pacific Islander
- ☐ Native Hawaiian
- ☐ Alaskan Native/American Indian

If the Government needs to contact you, how would you like this confidential communication to be received?

Phone Number: _____ **Phone call** ☐ **Text Message** ☐

E-mail Address: _____ **Preferred Language:** _____

Smoking Status: Smokes Everyday Smokes Some days Former Smoker Never Smoked

Prescribed Medicines

Check here if you're not taking any medications: ☐

MEDICATION: i.e. Lipitor	# OF REFILLS	STRENGTH: i.e. 10 mg	DOSE FORM: i.e. capsule	MD'S INSTRUCTION: i.e. 1 per day

Are you allergic to any medication? Please List each drug on a new line:
Check here if you do not have any medicinal allergies: ☐

Name of Drug: i.e. Penicillin	Symptom: i.e. headache

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment..
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

~~Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100~~

Neck Index Score _____

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score

Name:_____ Date:_____

Please check all that apply.
Do you CURRENTLY have? (if yes, check the appropriate boxes)

GENERAL
- ☐ Fatigue
- ☐ Fever
- ☐ Weight gain > 10 lbs
- ☐ Weight loss > 10 lbs

SKIN
- ☐ Nail changes
- ☐ New lesions
- ☐ Rash
- ☐ Skin color changes

HEENT
- ☐ Double vision
- ☐ Eye pain
- ☐ Eye redness
- ☐ Decreased hearing
- ☐ Earache
- ☐ Ear ringing
- ☐ Nose bleeds
- ☐ Dry mouth
- ☐ Hoarseness
- ☐ Oral ulcers
- ☐ Sore throat

NECK
- ☐ Neck pain
- ☐ Swollen glands

RESPIRATORY
- ☐ Chronic cough
- ☐ Decreased exercise tolerance
- ☐ Difficulty breathing
- ☐ Coughing up blood
- ☐ Sputum production
- ☐ Wheezing

BREAST
- ☐ Breast mass
- ☐ Breast pain
- ☐ Nipple discharge
- ☐ Skin changes

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Leg pain with walking
- ☐ Leg swelling
- ☐ Night awakening due to trouble breathing
- ☐ Palpitations
- ☐ Shortness of breath

GASTROINTESIONAL
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea

Doctors notes

GASTROINTESIONAL
- ☐ Vomiting
- ☐ Rectal bleeding
- ☐ Trouble swallowing

GENITOURINARY
- ☐ Vaginal discharge
- ☐ Menstrual irregularities
- ☐ Difficulty starting/stopping urinary stream
- ☐ Painful urination
- ☐ Change in urinary stream
- ☐ Increased frequency
- ☐ Blood in urine
- ☐ Loss of bladder control
- ☐ Nighttime urination
- ☐ Urinary retention
- ☐ Urethral discharge
- ☐ Impotence
- ☐ Penile lesions
- ☐ Testicular mass

MUSCULOSKELETAL
- ☐ Decreased range of motion
- ☐ Joint pain
- ☐ Joint redness
- ☐ Joint swelling
- ☐ Joint stiffness
- ☐ Muscle wasting
- ☐ Muscle weakness
- ☐ Muscle aches/pains

NEUROLOGICAL
- ☐ Loss of bowel control
- ☐ Dizziness/vertigo
- ☐ Headaches
- ☐ Numbness/tingling
- ☐ Passing out
- ☐ Seizures
- ☐ Tremor

PSYCHIATRIC
- ☐ Anxiety
- ☐ Change in sleep pattern
- ☐ Depression
- ☐ Hallucinations
- ☐ Suicidal thoughts

ENDOCRINE
- ☐ Appetite changes
- ☐ Cold intolerance
- ☐ Increased thirst
- ☐ Increased urination
- ☐ Hair changes
- ☐ Sexual dysfunction

HEMATOLOGY
- ☐ Easy bruising
- ☐ Enlarged lymph nodes
- ☐ Prolonged bleeding

Doctors notes

Initial if reviewed with patient: ____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

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 the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and I 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 on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, is my best interest.

I have read, and or have had read to me, the above consent. I have also had an 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.

To be completed by patient:

_____
Print Patient's Name

_____
Signature of Patient / Guardian

_____
Date Signed

To be completed by doctor or staff:

Name and address of clinic/office:

Tropicana West Chiropractic

6819 W. Tropicana Ave #100 Las Vegas, NV 89103

(702)364-5130

Print name (s) doctor (s) treating this patient:

William G. Leavitt D.C

Douglas Brady D.C.

Notice of Privacy Practices
Tropicana West Chiropractic

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Purpose of This Notice

The Joint Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, initiate payment, or conduct healthcare operations and for other purposes that are permitted or required by law. **Tropicana West Chiropractic (TWC) reserves the right to make changes in the Notice of Privacy Practices.** This notice describes your rights to access and control your protected health information. "Protected Health Information" is the information about you including demographic information, that may identify you and that relates to your past, present, or future physical or mental health condition and related health care services. Some of your care in our office may be provided in open areas, If you are not comfortable or agree with any procedure at any time throughout your visit, please let one of our staff members know; we have private consulting areas available upon request.

Who Will Follow This Notice

This notice describes the privacy policies of Tropicana West Chiropractic and that of:

- Any health care professional authorized to enter information into your medical records.
- All employees of Tropicana West Chiropractic.
- All contracted service providers for Tropicana West Chiropractic.

Our Pledge Regarding Your Medical Information

We are committed to protecting your personal health information. A confidential record of the care and services you receive at our office is created and maintained at our office. This notice applies to all of those records of your care.
The law requires us to:

- Ensure your personal medical information is kept confidential.
- Provide this notice that tells of our legal duties and privacy practices regarding your personal medical information.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable request you may have to communicate health information by alternative means or alternative locations.

All employees will follow the terms of this notice that is currently in effect. We may change the terms of this notice at any time without advance notice to you. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may obtain a copy by contactin our Privacy Officer at (702)364-5130.

We will not use or disclose your health information without your authorization, except as described in this notice. If you believe your privacy rights have been violated, you can file a complaint with our Compliance Officer or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment, and Health Operations

We will use your health information for treatment.
For example: Information obtained by the physician, chiropractic assistant, or any other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Upon request, we will also provide other physicians or a subsequent health care provider with copies of various reports pertaining to your care in our office.

We will use your health information for payment.
For example: A bill may be sent to you or insurance company. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis and procedures performed.

We will use your health information for regular health operations.
There are some services provided in our office through contacts with business associates. These would include diagnostic or laboratory services, or any entity contracted to maintain or install our data systems. To protect your health information, however, we require the business associates to sign a privacy agreement that they will appropriately safeguard your information.

Communication with family; Health pro[illegible]onals, using their best judgment, may dis[illegible]e to a family member, close personal friend, or any other person you authorize by written consent, health information relevant to that person's involvement in your care or payment related to your care.

Workers Compensation; We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health; As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement; We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

_____ I understand that my health care records maybe destroyed after a period of five years or any period of time designated by federal or state law.

_____ I understand **Tropicana West Chiropractic** will be contacting me regarding appointments, and insurance or billing matters, I am aware that if I should not be available at the time the call is made a message will be left.

Authorization and HIPAA Acknowledgement

Please read carefully and sign/initial here indicated.

I understand that under HIPAA, I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that TWC has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Signature of patient /Legal Guardian Date

_____

Print name of Patient/ Legal Guardian

I hereby authorize **Tropicana West Chiropractic**, to discuss and disclose any healthcare information including billing/account information on my behalf anytime; to the person(s) listed below: **(If you do not permit anyone access to this information on your behalf, leave this area blank)**

Print Authorized Person's Name	List authorized Party's Relationship to Patient	Patient's Initials
Print Authorized Person's Name	List authorized Party's Relationship to Patient	Patient's Initials

_____ _____

Signature of Tropicana West Chiropractic Employee as Witness Date

Revised 4/2018

Tropicana West Chiropractic

Financial Policy

From this point forward, please note the words "you" and "your" indicate the patient/financially responsible party. The Abbreviation "TWC" and the words "we" and "our" indicate Tropicana West Chiropractic.

Payment for services is due at the time services are rendered. We accept cash, checks and credit cards; MasterCard, Visa, Discover and American Express.

We would like you to be aware that you are ultimately responsible for knowing your insurance carrier information and your coverage/benefits including policy limitations, any co-pays, co-insurance, and deductible amounts for services rendered. Any such fees are due at the time services are rendered.

As a courtesy if you have health insurance and your benefits can be verified, we will inform you of your anticipated financial responsibility prior to services being rendered. **However, that quotation of benefits is not a guarantee of payment from your insurance or how claims will be processed by them.**

Also as a courtesy to you, we will submit a claim to your insurance company on your behalf. If your insurance coverage/carrier changes; please notify the billing department immediately. Insurance information that is not supplied to our office in a timely fashion could result in a denial of payment from your insurance company due to "timely filing limitations." **If this does occur, charges will be assigned to your responsibility**.

TWC will mail you a monthly statement after the 15th of every month. Balance is due in full by the 15th of the following month. If you are unable to pay the amount in full, please contact the billing department to make payment arrangements.

It is not the responsibility of TWC to make sure the address and phone number(s) we have on file for you are correct. If you have a change of name, address or phone number(s), you must notify our office immediately. If we do not have the correct address on file, we will assume you have been negligent with your payments to our office and your account could be turned over to a collections agency.

TWC charges a returned check fee of $25. This fee is in addition to any fees charged to us by our bank for the returned check.

Missed massage appointments without 24 hour notification to TWC will be subject to a $45 cancellation fee.

We understand that temporary financial problems may effect timely payment of your balance. We encourage you to communicate any such problems to our billing department so that we can assist you in the management of your account.

FINANCIAL POLICY AGREEMENT:

I have read and understand the Financial Policy of Tropicana West Chiropractic and I agree to comply with all financial and demographic responsibility required of me.

_____

Signature of Patient; if Patient is a Minor; Parent or Legal Guardian holding Financial Responsibility

_____ _____ ☐ Self ☐ Parent/Legal Guardian

Printed Name **Date** Relationship to Patient (Check Once)

INSURANCE RELEASE:

Assignment and Release: I hereby authorize TWC to bill my insurance company/companies on my behalf, and I authorize my insurance company/companies to make payments directly to TWC. I also authorize and understand the release of any information (personal, medical or otherwise) is required to process insurance claims. I acknowledge the information I have given TWC to be true and complete.

_____

Signature of Patient; if Patient is a Minor; Parent or Legal Guardian holding Financial Responsibility

_____ _____ ☐ Self ☐ Parent/Legal Guardian

Printed Name **Date** Relationship to Patient (Check Once)

_____ _____

TWC Employee Witness Signature Date

Revised 07/2017