Delran Chiropractic, PA
Wellness Center

3001 Bridgeboro Road
Delran, New Jersey 08075
Phone: 856-461-6262
Fax: 856-461-7798
www.delranchiropractic.com

Patient Intake Form
(please print clearly)

Patient Information

First Name: ____________________ Middle Name: ________ Last Name: ________________

DOB: ________________________ Sex (circle applicable): Male Female Other: ___________

Height: __________ Weight: __________ Social Security #: ________________________

Married/civil union (circle applicable): Married Single Divorced Widow(er)

Spouse name: __________________________________ # of children: ______________

Home #: __________________ Cell #: __________________ Wireless Carrier: __________

Address: ____

City: ________________________________ State: ______________ Zip Code: __________

Email: ____

Employer Information

Employed (circle applicable): Full time Part time Unemployed

Employer Name: ____________________________ Occupation: ____________________

Employer Address: ____

Employer City: __________________________ Employer State: ________ Employer Zip: ________

Work Supervisor Name: __________________________ Supervisor Phone #: ____________

Physical Work Duties: ____

Reason for Visit

Describe the reason for this visit: ____

Impact on life: ____

When did this concern begin? ____

Has this concern (circle applicable): Gotten Worse Stayed Constant Come and Gone

Does this concern interfere with (circle applicable): Work Sleep Daily Routine Other Activities

Explain: ____

Has this concern occurred before? Yes No

Explain: ____

Have you seen other doctors for this concern? Yes No

Doctor's Name: __________________________

Type of Treatment: ____

Results (circle applicable): Good Bad Indifferent

Chiropractic Experience

How did you find our office (circle applicable)? Newspaper Sign Community Event Mailing Google Patient

If applicable, who referred you to our office? ______________________________

Have you been adjusted by a Chiropractor before (circle applicable)? Yes No

If yes, what was the reason? ______________________________

Doctor's Name: ______________________

Date of last visit: ________________

Has any member of your family ever seen a Chiropractor? Yes No

Female Only *(please circle applicable options)*

Are you pregnant? Yes No

Are you nursing? Yes No

Are you taking birth control? Yes No

Do you have irregular cycles? Yes No

Do you experience painful periods? Yes No

Do you have breast implants? Yes No

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SOAP Notes

Name: ______________________ Patient #: ____________ Date: __________

What is your *typical* or *average* pain?

0 1 2 3 4 5 6 7 8 9 10

Level	Root	Motor	R	L	DTRs	R	L	Sensory	R	L
C4/5	5	Deltoid			Biceps			Lat Arm		
C5/6	6	Wr Ext			Brachio			Lat For		
C6/7	7	Triceps			Triceps			Mid Fin		
C7/1	8	Fn Flex						Med For		
L1/3								Ant Thigh		
L3/4	4	Ant Tib			Patellar			Med Ft		
L4/5	5	EHL			M Ham			Lat Leg		
L5/1	1	Peron			Achilles			Lat Ft		

Cervical Spine			
ROM	Norm	R	L
Flexion	60		
Extension	75		
Lat Bend	45		
Rotation	80		

	R	L	N
Compression			
Disctraction			
Spurling			
Soto Half			
Jackson			
George			
Valsalva			
Phalens			
Tinels			

Lumbar Spine			
ROM	Norm	R	L
Flexion	70		
Extension	25		
Lat Bend	25		

	R	L
SLR		
Braggard		
Kemp		
Fabre		
Millgram		
Valsalva		
Minors		
Lindners		
Ganslens		

Present Complaint ______________________________

Onset ______________________________

Prov/Pall ______________________________

Quality ______________________________

VAS ______________________________

Timing ______________________________

Other Doctors/Tests ______________________________

Previous Accidents/Trauma ______________________________

Medication ______________________________

NECK DISABILITY INDEX

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU. ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT -DAY SITUATION.

SECTION 1 - PAIN INTENSITY

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE

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

SECTION 3 – LIFTING

- ☐ I can lift heavy weights without causing extra pain.
- ☐ I can lift heavy weights, but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 – WORK

- ☐ I can do as much work as I want.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I can't do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

SECTION 5 – HEADACHES

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

SECTION 6 – CONCENTRATION

- ☐ I can concentrate fully without difficulty.
- ☐ I can concentrate fully with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating.
- ☐ I have a lot of difficulty concentrating.
- ☐ I have a great deal of difficulty concentrating.
- ☐ I can't concentrate at all.

SECTION 7 – SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed for less than 1 hour.
- ☐ My sleep is mildly disturbed for up to 1-2 hours.
- ☐ My sleep is moderately disturbed for up to 2-3 hours.
- ☐ My sleep is greatly disturbed for up to 3-5 hours.
- ☐ My sleep is completely disturbed for up to 5-7 hours.

SECTION 8 – DRIVING

- ☐ I can drive my car without neck pain.
- ☐ I can drive as long as I want with slight neck pain.
- ☐ I can drive as long as I want with moderate neck pain.
- ☐ I can't drive as long as I want because of moderate neck pain.
- ☐ I can hardly drive at all because of severe neck pain.
- ☐ I can't drive my care at all because of neck pain.

SECTION 9 – READING

- ☐ I can read as much as I want with no neck pain.
- ☐ I can read as much as I want with slight neck pain.
- ☐ I can read as much as I want with moderate neck pain.
- ☐ I can't read as much as I want because of moderate neck pain.
- ☐ I can't read as much as I want because of severe neck pain.
- ☐ I can't read at all.

SECTION 10 – RECREATION

- ☐ I have no neck pain during all recreational activities.
- ☐ I have some neck pain with all recreational activities.
- ☐ I have some neck pain with a few recreational activities.
- ☐ I have neck pain with most recreational activities.
- ☐ I can hardly do recreational activities due to neck pain.
- ☐ I can't do any recreational activities due to neck pain.

PATIENT NAME ______________________________ DATE ______________

SCORE ____________ [50] BENCHMARK -5 = ____________

Copyright: Vernon H. and Hagino C., 1987. Vernon H, Mior S. The Neck Disability Index: A study of reliability and validity. Journal of Manipulative and Physiological Therapeutics 1991; 14:409-415. Copied with permission of the authors.

Patient Acct # ________
Doctor #__________
Reviewed By ________

Oswestry Disability Index for Lower Back Pain

Patient Name:______________________ **File #**____________ **Date**__________

Please Read: This questionnaire has been designed to give the doctor information on how your pain has affected your ability to manage everyday life. ***PLEASE ANSWER EVERY SECTION AND MARK IN EACH SECTION ONLY ONE ANSWER*** that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please check just one which most closely describes you

SECTION 1- PAIN INTENSITY

- o I can tolerate the pain I have without pain killers.
- o The pain is bad but I manage without pain killers.
- o Pain killers give me complete relief of pain.
- o Pain killers give me moderate relief of pain.
- o Pain killers give me very little relief of pain.
- o Pain killers have no effect on pain and I do not use them.

SECTION 2- PERSONAL CARE (Washing, Dressing, etc.)

- o I can look after myself normally, without extra pain.
- o I can look after myself normally, but it causes extra pain.
- o It is painful to look after myself, but I am slow and careful.
- o I need some help but manage most of my personal care.
- o I need some help everyday in most aspects of self-care.
- o I do not get dressed: I wash with difficulty and stay in bed.

SECTION 3- LIFTING

- o I can lift heavy weights without causing pain.
- o I can lift heavy weights, but it gives extra pain.
- o Pain prevents me from lifting heavy weights off of the floor, but I manage if they are conveniently positioned.
- o Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are convenient.
- o I can lift light weights only.
- o I cannot lift or carry anything at all.

SECTION 4-WALKING

- o Pain does not prevent me from walking any distance.
- o Pain prevents me from walking more than 1 Mile.
- o Pain prevents me from walking more than ½ Mile.
- o Pain prevents me from walking more than ¼ Mile.
- o I can only walk using a stick/cane or crutches.
- o I am in bed most of the time and have to crawl to the toilet.

SECTION 5-SITTING

- o I can still sit in a chair as long as I like.
- o I can only sit in my favorite chair as long as I like.
- o Pain prevents me from sitting more than an hour.
- o Pain prevents me from sitting more than a ½ hour.
- o Pain prevents me from sitting more than 10 minutes.
- o Pain prevents me from sitting at all.

SECTION 6- STANDING

- o I can stand as long as I want without extra pain.
- o I can stand as long as I want but it gives extra pain.
- o Pain prevents me from standing more than an hour.
- o Pain prevents me from standing more than a ½ hr.
- o Pain prevents me from standing more than 10 min.
- o Pain prevents me from standing at all.

SECTION 7-SLEEPING

- o Pain does not prevent me from sleeping well.
- o I can sleep well only by using tablets.
- o Even when I take tablets, I have less than 6 hours.
- o Even when I take tablets, I have less than 4 hours.
- o Even when I take tablets, I have less than 2 hours.
- o Pain prevents me from sleeping at all.

SECTION 8- EMPLOYMENT/HOMEMAKING

- o Job/homemaking causes no extra pain.
- o Job/homemaking increases pain, but I can still perform.
- o Can perform most duties, pain prevents heavier activity.
- o Pain prevents me from doing anything but light duties.
- o Pain prevents me from doing even light duties.
- o Pain prevents me from doing ANY job/homemaking.

SECTION 9- SOCIAL LIFE

- o My social life is normal and causes no extra pain.
- o My social life is normal but increases the degree of pain.
- o Pain has no significant effect on my life apart from limiting my more energetic interests (dancing, etc.).
- o Pain has restricted my social life and I do not go out as often.
- o Pain has restricted my social life and I do not go out.
- o I have no social life because of pain.

SECTION 10- Traveling

- o I can travel anywhere without pain.
- o I can travel anywhere but with extra pain.
- o Pain is bad but I can manage to journey over 2 hours.
- o Pain restricts me to journeys over 1 hour.
- o Pain restricts me to short necessary journeys less than 30 min.
- o Pain prevents me from traveling except to the doctor or hospital.

Total: ________

Patient Signature______________________________ **Date** __________

Delran Chiropractic, PA
Wellness Center
REVIEW OF SYSTEM FORM

Name: ______________________________ Date: ______________
Tobacco Use: YES/NO How much per day? _______ How Long? _______ Date Quit_________
Alcohol Use: How much per day? _______
Caffeine (Coffee, Teas, and/or Colas): How much per day? _______

PAST ILLNESSES

	Yes	No
Alcoholism		
Anemia		
Asthma		
Cancer		
Depression		
Diabetes		
Drug Abuse		
Epilepsy/Seizures		
Glaucoma		
Heart Disease		

	Yes	No
Hepatitis		
High Blood Pressure		
High Cholesterol		
HIV		
Lung Disease		
Mental Illness		
Osteoarthritis		
Osteoporosis		
Other Immune Disease		
Phlebitis		

	Yes	No
Phlebitis		
Rheumatic Arthritis		
Stroke		
Thyroid Disease		
Tuberculosis (TB)		
Ulcer in GI Tract		
Venereal Disease		
Other:		
Other:		

PAST SURGICAL HISTORY: (PLEASE INCLUDE DATES)

____
____
____
____

REVIEW OF SYSTEMS-PLEASE CHECK EACH ITEM "YES" OR "NO" AS THEY RELATE TO YOUR HEALTH:

	Yes	No
NERVOUS SYSTEM:		
Epilepsy		
Seizures		
Fainting Spells		
Loss of Consciousness		
ADHD		
ADD		
Cerebral Palsy		
Head Injury		
Headaches		
Migraines		
PSYCHOSOCIAL:		
Anxiety		
Depression		
Counseling Service		
Mental Illness		
HEART:		
High Blood Pressure		
Chest Pain		
Angina		
Heart Attack		
Pacemaker		
Mitral Valve Prolapse		
Heart Murmur		
Irregular Heartbeat		
Palpitations		
Skipped Beats		
Heart Surgery		
LIVER:		
Hepatitis		
Jaundice		
Liver Disease		

	Yes	No
LUNG:		
Asthma		
Hay Fever/Sinus		
Emphysema/COPD		
Shortness of Breath		
Croup		
Bronchitis		
Recent Cold/Cough		
TB		
Pneumonia		
Chew Tobacco		
ANESTHESIA:		
Nausea/Vomiting After		
Family History - Problems		
GI/GU		
Hiatal Hernia		
Stomach Ulcer		
Kidney Disease		
Unexplained Recent Weight Loss/Gain		
Gastric Reflux		
Indigestion		
Motion Sickness		
ENDOCRINE:		
Diabetes		
Thyroid Disease		
Insulin Dependent		
Hypoglycemia		
DENTAL:		
Bridges, Partials, Dentures		
Loose or Missing Teeth		
TMJ		

	Yes	No
MUSCULOSKELETAL:		
Arthritis		
Painful Stiff Joints		
Prosthesis: ___________		
Back Pain		
Metal Implants: ___________		
Physical Limitations: ___________		
BLOOD:		
Bleeding Disorder		
Previous Blood Transfusions		
Eye Glaucoma		
Eye – Other		
AIRWAY:		
Problem Opening Mouth Wide		
Problem Turning Head in Any Direction		
Sleep Apnea		
Snoring		
ALLERGIES:		
Latex		
Medications		
Dyes/Tape		
Shellfish		
Foods		
Loss of Strength		
Numbness		
Headaches		
Tremors		
WOMEN'S HEALTH:		
Pregnant?		

SIGNATURE/REVIEWING PHYSICIAN ______________________________

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Electronic Health Records Intake Form

In Compliance with Medicare requirements for the government EHR incentive program

First Name__________________ Last Name__________________________ Zip Code________________

Email Address__________________________ Cell#__________________ Cell Provider________________

Preferred method of Communication for patient reminders (Circle one): Text message / Phone Call

DOB: ___/___/______ Gender(Circle One): Male / Female Preferred Language: ________________

Smoking Status(Circle One): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race(Circle One): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / Decline to Answer

Ethnicity(Circle One): Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

[ ] I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient signature:______________________________________ **Date:**________________

For Office use only

Height:____________ **Weight:**________ **Blood Pressure:**________/________

DELRAN CHIROPRACTIC PA

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4-14-2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other health care provider providing treatment to you. Treatment may be administered in an open room format.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare Operations: include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give, us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice, we may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing health information that is directly relevant to the persons involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies; x-rays, or other similar forms of health information.

Marketing Health-Related services: We will not use your health information for marketing communications without your written authorization for example. (puzzle boards, thank you board)

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are.

a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as rescheduling missed appointments, phone calls, voicemail messages, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice; If you request copies, we will charge you $0.25 for each page, $10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we of our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14,2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you received this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form. QUESTIONS AND COMPLAINTS. If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your, privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if, you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr Jason Polino DC
Office Telephone: 856-461 -6262
Billing Telephone: 8564616249 contact person: Jeni Polino
Fax 856-461-7798
Address: 3001 Bridgeboro Road
Delran ,NJ 08075

Patient's Signature & Date:______________________________

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Patient Name: ____

Patient Address: ____

Authorization & Assignment

I hereby authorize my insurance company to make payment directly to Delran Chiropractic, PA the expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This payment shall not exceed my indebtedness to above mentioned assignee, and I have agreed to pay, in current manner, any balance of said professional service charges over and above this insurance payment. If for any reason the insurance company does not pay all or part of my bill, I realize I am responsible for the balance.

Patient Signature: ________________________________

Date: ____________________

Payment for Professional Service Is Due Upon Receipt of This Statement

I hereby agree to reimburse my insurance company for any amounts of overpayment in excess of amounts payable under this group policy. I hereby authorize any physician, hospital, pharmacy, insurance company, employer, or organization to release any information regarding the medical history, treatment, disability, or benefits payable for this claim to my insurance company. A photocopy of this authorization shall be as valid as the original.

Patient Signature: ________________________________

Date: ____________________

Delran Chiropractic, PA
Tax ID: 22-2238792

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Dr. Jason Polino, DC
Dr. Nancy Cillo, DC, CNT

Patient Care — Insurance Agreement

In consideration of your undertaking to care for me, I agree to the following:

1. In the event any insurance company obligated by contractual agreement to make payment to me or you for the charges made for your services refuses to make such payment upon demand by you or does not make payment within 60 days of your billing, I will become personally responsible for that amount. I will have 30 days to clear that account by calling my insurance company after being notified by your office. If the amount is not cleared by 30 days, I hereby authorize you to collect any outstanding amount on my credit card listed below.
2. Any insurance checks that may be forwarded to me for services received at the chiropractic office(s) and not previously paid for will be endorsed by me and turned over to Delran Chiropractic, PA within 5 days of receipt for payment on my account. If I do not clear this portion of my account within 5 days of receipt of said payment, I hereby authorize you to collect the full amount of my account on the credit card listed below.
3. Any balance that is on my account will be paid for and cleared within 30 days of notification of the amount. If a balance remains past 30 days, I hereby authorize you to collect the full amount of my account on the credit card listed below.
4. This clinic does not promise that an insurance company will pay, nor does the clinic promise that an insurance company will or should pay the difference.
5. The clinic will not enter into a dispute with an insurance company over reimbursement or the amount of reimbursement. This is the patient's obligation.
6. All deductible amounts must be paid prior to insurance submittal.
7. Waiting for insurance payment is a courtesy and may be withdrawn at any time.
8. If the patient discontinues care for any reason other than discharge by the doctor, then the bill is due and payable in full *immediately,* regardless of any claims submitted.
9. I also consent to the administration of chiropractic care, diagnostic, and therapeutic recommendations by Delran Chiropractic, PA and its associates. Further, if during the course of care it is determined by the doctor that an additional or different procedure or tests are medically necessary, I consent to do that as well.

Patient Name: ______________________________
Address: ______________________________
Credit Card (circle applicable): Mastercard AMEX Discover VISA
Card Number: ____________________ Expiration Date: ______________ CVC: ________
Patient Signature: ______________________________ Date: ______________
Witness Signature: ______________________________ Date: ______________