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Phone: 804-608-3045

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Ryan M. Heid, D.C.

Katherine E. Brus, D.C.

Name: _____
First Middle Initial Last Preferred/Nickname

Address: _____

City State Zip

Mobile Phone: _____ Mobile Phone Carrier: _____
 Email: _____ Other Phone: _____

SSN#: - - Date of Birth : ___/___/___ Gender: M F

Are you? Single Married Divorced Other Spouse's Name: _____

Employer: _____ Occupation: _____

Address: _____

City State Zip

Insured Information (if other than patient)

Name: _____
First Middle Initial Last

Address: _____

City State Zip

Home Phone: () - Fax: () - E-mail Address: _____

SSN#: - - Date of Birth : ___/___/___ Gender: M F

How did you find us? Patient? If yes, who? _____ Facebook
 Other Doctor? If yes, who? _____ Other? Explain: _____
 Google _____

1. What date did your symptoms begin? ___/___/___

2. Have you had these symptoms before? _____; if yes, when? _____

3. How did this happen? _____

4. Is this injury work or auto accident related?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
5. Are your arms or legs involved?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
6. Please describe your chief complaint	_____	

1. What makes your chief complaint better? (Ice, Heat, Medication, etc?) _____

2. What makes your chief complaint worse? (Certain movements/activities etc) _____

3. Are you currently taking any medications? If so, please list: _____

4. Have you had any recent imaging studies? X-ray? MRI? CT scans? Yes No

5. Do you have a primary Care Physician? Yes No

If yes, who is your PCP? _____

6. Are you currently seeing any other physicians / specialists? Yes No

If yes, who/what specialty? _____

7. Have you ever seen a Chiropractor? Yes No

8. Does your complaint keep you from performing any of your normal daily activities? If yes, please

explain: _____

9. Are you taking any Vitamins/Supplements? If yes, please list: _____

10. How many ounces of water do you drink per day? _____

11. Are you drinking any caffeinated beverages? If so, how many per day? _____

12. Do you exercise or stretch regularly? If so, what types of exercise? _____

13. What is your preferred sleeping position? Back Side Stomach Combination

Have you ever had or are you having problems with any of the following?

<input type="checkbox"/> No	<input type="checkbox"/> Yes	Headaches	If yes, how often and when?	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Dizziness	If yes, how often and when?	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Sinus pain	If yes, how often and when?	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Neck pain	If yes, how often and when?	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Upper back pain	If yes, how often and when?	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Mid-back pain	If yes, how often and when?	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Low back pain	If yes, how often and when?	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Shoulder pain	If yes, how often and when?	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Chest pain	If yes, how often and when?	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Heart	If yes, how often and when?	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Stomach	If yes, how often and when?	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Bladder	If yes, how often and when?	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Liver	If yes, how often and when?	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Kidney	If yes, how often and when?	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Colon	If yes, how often and when?	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Hip	If yes, how often and when?	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Circulation	If yes, how often and when?	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Prostate	If yes, how often and when?	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Breast	If yes, how often and when?	_____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	1. Have you ever been in an accident?		
<input type="checkbox"/> No	<input type="checkbox"/> Yes	2. Have you ever been hospitalized or had any surgery?		
<input type="checkbox"/> No	<input type="checkbox"/> Yes	3. Have you ever had measles, mumps, rheumatic fever, sexually transmitted disease or any other type of infection?		
<input type="checkbox"/> No	<input type="checkbox"/> Yes	4. Have you or your family ever had cancer?		
<input type="checkbox"/> No	<input type="checkbox"/> Yes	5. Have you or a family member ever been diagnosed with diabetes?		
<input type="checkbox"/> No	<input type="checkbox"/> Yes	6. Has any family member ever had neck, back, or spinal problems?		
<input type="checkbox"/> No	<input type="checkbox"/> Yes	7. Do you drink alcohol, smoke cigarettes, or ever use any recreational drugs?		
<input type="checkbox"/> No	<input type="checkbox"/> Yes	8. If female, any possibility of currently being pregnant?		

If you answered "yes" to any of the items above, please explain: _____

Patient Signature _____ Date _____

Parent or Guardian _____ Date _____

Please use the appropriate letters below to indicate the type and location of your sensations right now.

A=ACHE

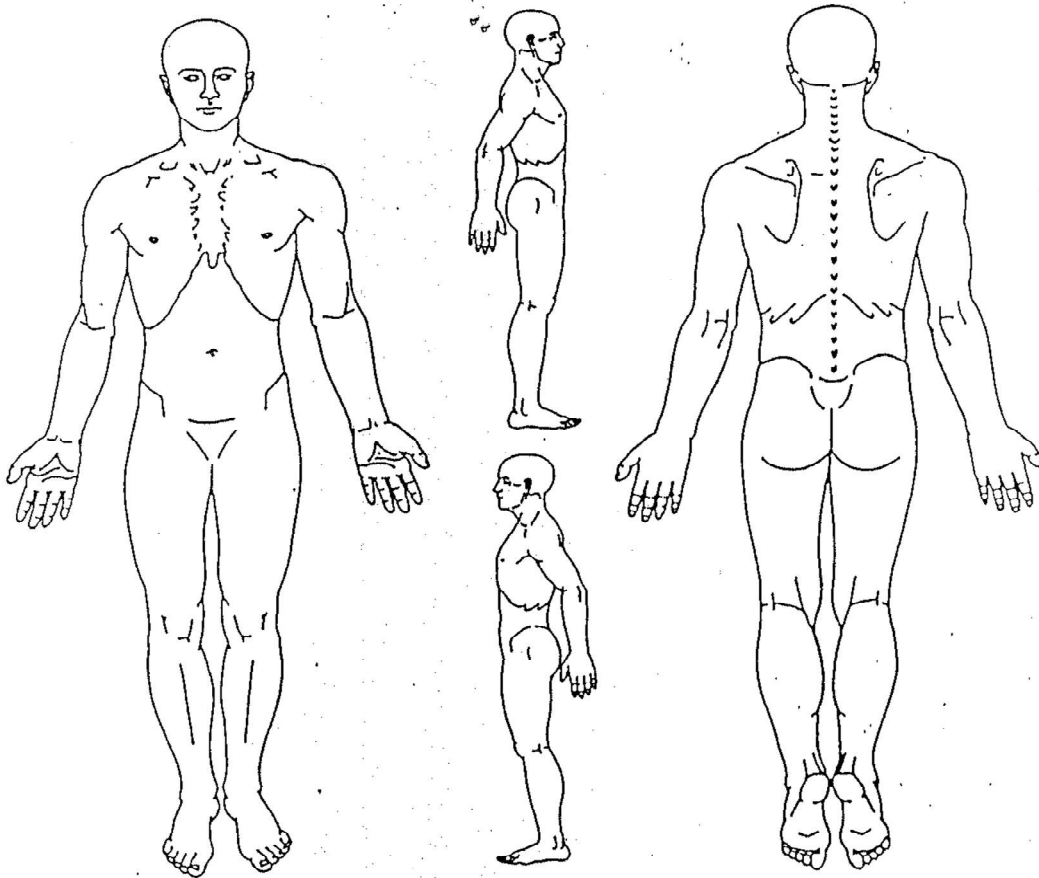
B=BURNING

S=STABBING

N=NUMBNESS

P=PINS & NEEDLES

O=OTHER



Please rate the severity of your pain by circling a number on each line below.

RIGHT NOW	No pain	0	1	2	3	4	5	6	7	8	9	10 Unbearable Pain
BEST in the past week	No pain	0	1	2	3	4	5	6	7	8	9	10 Unbearable Pain
AVERAGE in past week	No pain	0	1	2	3	4	5	6	7	8	9	10 Unbearable Pain
WORST in past week	No pain	0	1	2	3	4	5	6	7	8	9	10 Unbearable Pain

Patient Signature

Date

Print Name

OFFICE POLICY FOR FINANCES AND INSURANCE

1. We will need to verify coverage on all patients prior to beginning treatment or the patient will be financially responsible for all costs until such verification of coverage occurs. We will provide you with a copy of your verification of coverage from your third-party payor. We ask that you call your insurance provider to verify its accuracy.
2. Should your insurance provider quote your coverage differently than what was provided to us, as noted on the verification of coverage, please notify us as soon as possible.
3. You will receive copies of EOB's (explanation of benefits/payments to your Chiropractor) from your insurance company. They will come in the mail. Please open each one and compare what the EOB states as your financial responsibility vs. the amount you pay each visit in our offices. Any differences between the two should be brought to our attention immediately. If additional amounts are due, please be prepared to pay that amount at your next visit. After reviewing the EOB, please place it into the manila folder that was given to you on your first visit, so that you will have all your Chiropractic records in one place.
4. We will file all claims as a courtesy and/or requirement for third party reimbursement, however, you may still be held responsible for payment should such claim be denied.
5. We allow up to 60 days before claims will be the responsibility of the patient to pay. Interest on the claims will not occur until 30 days past the patient's responsibility date or thirty days after denial of third-party payment, whichever occurs first.
6. Statements will only be sent if there is a balance due by the patient.
7. Responsibility for obtaining and maintaining referrals for HMO plans is that of the patient. We cannot alter or modify dates of service (or anything else) to accommodate improper filing procedures. If coverage is verified after a treatment date in which the patient paid in full, we will file that claim as a courtesy and the patient will be eligible for a refund after we receive payment for such date.
8. Our office will need to be notified immediately if there is any change in the following: health insurance, patient address, patient home telephone number, coverage termination or cancellation or any other reason that may affect third party reimbursement.
9. Non-compliance for payment due may result in a \$25.00 late payment/no payment and/or interest charges.
10. Deductibles and all co-payments are expected at the time of service and may be paid ahead.
11. Unless other arrangements have been made, if a patient's treatment plan is greater than once every 3 weeks, the patient will no longer be eligible for health insurance assignment. Most health insurance considers this to be maintenance care and does not reimburse for this. You may still be eligible for insurance reimbursement; however, we will ask that the patient pay us and then the patient can submit the bill to their insurance carrier for direct reimbursement.
12. This office does not promise that an insurance company will pay for usual and customary charges of this office, nor will this office enter into any dispute with an insurance company over reimbursement or the amount of reimbursement.
13. I understand, should additional information be asked from Midlothian Family Chiropractic Center (i.e. notes), that I would allow 15 working days for such requested information.
14. I have read over and agree to the financial considerations for treatment costs.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

FINANCIAL CONSIDERATIONS

1. Your first visit to our office will consist of an orthopedic-neurological examination. If determined medically necessary, you may be referred for imaging studies (X-Ray, MRI, CT) You may, also, receive palliative therapy. Therapies for most conditions include interferential stimulation, intersegmental traction, manual therapy, therapeutic exercises, stretching, etc.
2. On your second visit the doctor will provide you with a report of findings and recommendations for care. After meeting with the doctor, our receptionist will review the financial obligations of your care. Chiropractic adjustments will only be performed after notification and mutual agreement of financial costs, treatment plan and terms of care.
3. A schedule of costs for procedures is provided for you below:

Examination:	New Patient Brief Exam	= \$90.00
	New Patient Intermediate Exam	= \$115.00
Re-examination:	Established Patient Brief Exam	= \$45.00
	Established Patient Intermediate Exam	= \$70.00
Office Visit/Adjustment:	Adjustment (1 to 2 regions)	= \$55.00
	Adjustment (3 to 4 regions)	= \$60.00
	Adjustment (5 or more regions)	= \$65.00
	Adjustment (extremities)	= \$35.00
Ancillary Treatments:	Interferential Stimulation	= \$25.00
	Intersegmental Traction	= \$12.00
	Manual Therapy	= \$30.00
	Therapeutic Exercises/Stretching	= \$30.00
Massage Therapy:	30 Minute Massage/with hot stones	= \$45/\$60
	60 Minute Massage /with hot stones	= \$90/\$120

Self Pay Membership Plan is available for those without insurance, those that elect to not use their insurance or for patients receiving maintenance care.

**Preferred Chiropractic Doctor Membership = \$37 per contract year and allows for discounted self pay options.
 With membership: Office visit including spinal/extremity adjustment and ancillary therapeutic treatments = \$65
 With membership Prepay options are also available and reduce each per visit charge.**

6 prepaid visits	\$350 (\$58.33/visit)
12 prepaid visits	\$650 (\$54.17/visit)
24 prepaid visits	\$1200 (\$50 / visit)

I have read and understand the cost of services provided. These prices are subject to change without notice.

Patient Signature _____ Date _____

Parent or Guardian Signature _____ Date _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and / or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Midlothian Family Chiropractic Center all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect for seven years or until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

I have read your authorization and legal assignment of benefits and agree to its terms. My signature authorizes you to disclose my PHI in the manner described above and acknowledges that I will receive a copy of this completed form for my own records.

_____	_____	_____
Print Patient Name	Signature	Date
_____	_____	_____
Print Parent or Guardian Name	Signature	Date

CONSENT TO TREATMENT

I hereby certify all information provided on the patient registration information form is complete, truthful and to the best of my knowledge. I have received and read the notice of privacy practices for Midlothian Family Chiropractic Center. I authorize Midlothian Family Chiropractic Center to perform Chiropractic manipulations, therapeutic modalities, x-ray examinations, consulting services, diagnostic procedures and any other procedure necessary for treatment. I understand that any outstanding account balance will be subject to 18% annual interest rate. I also understand that any late payments will be subject of a \$25 service charge per billing cycle. In addition, I understand that any outstanding balance owed to Midlothian Family Chiropractic Center that becomes delinquent will result in legal action to collect the outstanding balance and that I will incur filing fees, attorney fees or whatever fees may occur as a result of my delinquent account. I understand these fees will total no less than 33 1/3% of monies owed. I also understand that if an appointment is cancelled or missed without 24-hour notification, that I will incur a \$25 fee, as another patient may have needed the time that I was scheduled. I have also chosen to receive chiropractic care for my specific condition understanding my other options for treatment as well as the risks involved. Furthermore, any returned checks will automatically incur a \$35 service charge. If I am not of legal age my parent or guardian will in turn guarantee my obligations to Midlothian Family Chiropractic Center and that the patient or guardian consents to treatment performed by Midlothian Family Chiropractic Center for the minor (patient).

_____	_____	_____
Print Patient Name	Signature	Date
_____	_____	_____
Print Parent or Guardian Name	Signature	Date