Teays Valley Chiropractic P.L.L.C
3 Station Place Hurricane, WV 25526
Phone: (304) - 757-7266 Fax: (304) 757-9865

First Name: _____ Last Name: _____ Middle: _____
Gender: M F Date of Birth: __/__/__ Age: ___ SS# _____
Home Address: _____
City: _____ State: _____ Zip: _____
Cell Phone: _____ Email: _____
Employer Name: _____ Phone #: _____
Employer Address: _____
City: _____ State: _____ Zip: _____

**SPOUSE or GUARDIAN**
Last Name: _____ First Name: _____ Middle: _____
Employer Name: _____ Phone #: _____
Date of Birth: __/__/__ SS# _____
**EMERGENCY CONTACT** (Name and address of nearest relative or friend not living with you)
Last Name: _____ First name: _____ Middle: _____
Cell Phone: _____ Relationship to Patient: _____
**CURRENT COMPLAINT**
Name of Injury: ( ) Automobile* ( ) Work ( ) Other
Please Describe: _____
Date of Injury: _____ Date Symptoms appeared: _____
List of other practitioners seen for this injury/condition? _____
Have you ever been under chiropractic care? _____
If yes, please describe _____

**INSURANCE INFORMATION**
Name of party responsible for payment _____ Phone: _____
Do you have health insurance? **YES NO** Name of Company: _____
*If auto accident, please provide: Insurance Company Name/Lawyer _____
Contact Person _____ Phone # _____
Claim Number: _____

**My Certification**

I certify that the above information is correct and I request services.
X_____ Date: _____
Signature of patient or person acting on patients behalf

**My Privacy**

I have received a copy of the Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan, and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third-party payers; Conduct normal healthcare operations such as quality assessments and accreditation.

X _____ Date: _____
Signature of patient or person acting on patients behalf
**Name of the Insured** _____
I understand and agree that health/accident insurance policies are an arrangement between the insurance carrier and myself. I understand and agree that all services rendered to me and charges are my personal responsibility for timely payment. I understand that is I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature _____ Date: _____
Guardian's Signature _____ Date: _____

turn over →

Fill out entire page!

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Date_____ Patient Name_____ DOB: _____

**Main Problem:**

What pain causes you to come to the office? _____

What caused the pain? _____

When did the pain start? _____ How long does this pain last? _____

How bad is the pain? (Circle one- 1= mild pain-10=Intense pain) 1 2 3 4 5 6 7 8 9 10

Circle the word or words that best describe the pain:
Cramping, Aching, Dull, Sharp, Shooting, Stiffness, Tingling, Throbbing, Burning, Pressure like, Numbness

How often does the pain occur? (Circle one) Occasional, Frequent, Constant

Does the pain travel to any other area? _____
What makes this pain better? _____
What makes this pain worse? _____
What else have you done to treat this pain? _____

**Other Problem:**

What other pain do you have? _____
What caused this pain? _____
When did this pain start? _____ How long does this pain last? _____

How bad is this pain? (Circle one- 1 = mild pain- 10 = intense pain) 1 2 3 4 5 6 7 8 9 10

Circle the word or words that best describe the pain:
Cramping, Aching, Dull, Sharp, Shooting, Stiffness, Tingling, Numbness, Throbbing, Burning, Pressure like

How often does this pain occur? (Circle one) Occasional, Frequent, Constant

Does this pain travel to any other area? _____
What makes this pain better? _____ Worse? _____
What else have you done to treat this pain? _____

Surgeries/Hospitalizations/Injuries: List Below:

_____

_____

Current Medications/Purpose: **(LIST ALL)**

_____

_____

_____

# Review of Symptoms

The following list of conditions may seem unrelated to your current health problem. However, these problems may influence your overall diagnosis, treatment plan and whether your case is accepted in this office.

Name:_____ DATE:_____

## CHECK ANY OF FOLLOWING DISEASES YOU HAVE HAD:

__Alcoholism
__Anemia
__Anorexia
__Appendicitis
__Arthritis
__Asthma
__Cancer
__Cataracts
__Chicken Pox
__Diabetes
__Diptheria
__Eczema
__Epilepsy
__Emphysema
__Fractures
__Headaches
__Glaucoma
__Goiter
__Gout
__Heart Disease
__Hepatitis
__Herniated Disk
__Influenza
__Kidney Disease
__Liver Disease
__Lumbago
__Malaria
__Measles
__Mental Disorder
__Migraines
__Mumps
__Osteoporosis
__Pleurisy
__Pneumonia
__Polio
__Psychiatric Care
__Rheumatic Fever
__Scarlet Fever
__Small Pox
__Stroke
__Suicide Attempt
__Tonsilitis
__Tuberculosis
__Tumors
__Typhoid Fever
__Ulcers
__Venereal Infection
__Whooping Cough

## CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST
## CIRCLE ANY CURRENT HEALTH PROBLEMS

MUSCUO-SKELETAL
__Low Back Pain
__Pain Between Shoulders
__Neck Pain
__Arm Pain
__Joint Pain/Stiffness
__Walking Problems
__Difficult Chewing/Clicking Jaw

NERVOUS SYSTEM
__Numbness
__Paralysis
__Dizziness
__Forgetfulness
__Confusion/Depression
__Fainting

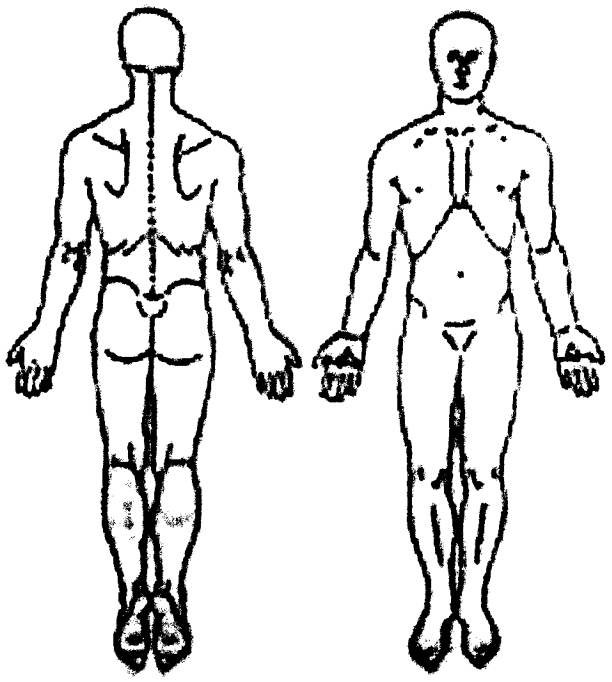
GENERAL
__Allergies
__Loss of Sleep
__Fever
__Headaches

GASTRO-INTESTINAL
__Poor/excessive appetite
__Gas/Bloating After Meals
__Heartburn
__Black/Bloody Stools
__Colitis

GENITO-URINARY
__Bladder Trouble
__Painful/Excessive Urination
__Discolored Urine

CARDIO/RESPIRATORY
__Chest Pain
__Shortness of breath
__Blood Pressure Problems
__Irregular Heartbeat
__Lung Problems/Congestion
__Varicose Veins
__Ankle Swelling

EENT
__Vision Problems
__Dental problems
__Sore Throat
__Ear Aches
__Hearing Difficulty
__Stuffed Nose



Please outline on the diagram the area of your discomfort.

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## Review of Systems ( Con't)

__Excessive thirst
__Frequent Nausea
__Vomiting
__Diarrhea
__Constipation
__Hemorrhoids
__Gall Bladder Trouble
__Weight Gain/Loss
__Abdominal Pain

MALE/FEMALE
__Menstrual Irregularity
__Menstrual Cramping
__Vaginal Pain/ Infections
__Breast Pain/Lumps
__Genital Herpes
__Currently Pregnant

## OTHER HISTORY

Do you smoke? __YES __No If yes, how many per day?_____
Do your drink? __YES __NO If yes, How much?_____
Are your pregnant?__YES __NO Date of last physical exam_____
List Past Illnesses_____

### FAMILY HISTORY

Please circle any that apply to your family history

HIGH BLOOD PRESSURE:
MOM DAD BROTHER SISTER GRANDPARENT

HEART DISEASE:
MOM DAD BROTHER SISTER GRANDPARENT

STROKE:
MOM DAD BROTHER SISTER GRANDPARENT

DIABETES:
MOM DAD BROTHER SISTER GRANDPARENT

ARTHRITIS:
MOM DAD BROTHER SISTER GRANDPARENT

SCOLOSIS:
MOM DAD BROTHER SISTER GRANDPARENT

CANCER:
MOM DAD BROTHER SISTER GRANDPARENT
WHICH TYPE:

_____

# Notice of Privacy Practices

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

Your patient records will be reviewed by your attending physician and staff members of this practice. The information will be used for the purposes of treatment, payment and day-to-day healthcare operations (including referrals, the scheduling of tests and labs, etc.) We may use this information to remind you of upcoming appointments, and to offer information to you concerning treatment and other healthcare services. We take every precaution to protect your health information through administrative, physical and technical safeguards.

**You have the right under this Notice of Privacy Practices to:**

* Request restrictions
* Receive confidential communications
* Inspect & copy protected health information (there will be a fee for copying)
* Amend information
* Receive an accounting of disclosures for any purposes other than treatment, payment, and day-to-day operations.

**Consent to Use and Disclosure of Health Information For Treatment, Payment, or Health Care Operations**

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand this information serves as a:

* Basis for planning my care and treatment.
* Means of communication among the many health professionals who contribute to my care.
* Source of information for applying my diagnosis and surgical information to my bill.
* Means by which a third-party payer can verify that services billed were actually provided.
* Tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

**All patients must sign a "Consent to use and Disclose", if the patient refuses to sign the consent, the physician will not provide medical treatment.

I understand and have been provided with a Notice of Privacy Practices and understand that a more complete description of information uses and disclosures will be provided upon written request.

If you feel that your medical record has not been properly protected please notify our privacy officer at Teays Valley Chiropractic, PLLC. We maintain the right to modify the privacy practices and will make the new notices immediately available for review. I have read and understood the information provided.

**Patient Signature** _____ **Date**_____

**Witnessed** _____ **Date**_____

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Massage Therapy Agreement

Due to an increased number of appointments scheduled with our massage therapists, Teays Valley Chiropractic has adopted the following policy. We must receive at least a 2 hour notice of your inability to keep a scheduled massage therapy appointment. Failure to do so will result in a $25.00 fee that can not be billed to your insurance and must be paid prior to rescheduling another massage. While Teays Valley Chiropractic collects this fee, it will in turn be paid directly to our massage therapist for her time. Additionally, in the event that you are 15 minutes late for your appointment, Teays Valley Chiropractic reserves the right to fill your remaining scheduled time. In the event that we are able to fill this appointment, you will not be billed.

Thank you for your consideration and cooperation in this matter. Your signature below indicates you have read and agree to the above stated policy.

_____
Patient Name

_____ _____
Patient Signature Date

_____ _____
Witness Date

Teays Valley Chiropractic
Dr. J.B. Marinacci
3 Station Place Way Hurricane, WV 25526
PH: (304) 757-7266 Fax: (304) 757-9865

# INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Teays Valley Chiropractic:

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course treatment for my present condition (s) and for and future condition (s) for which I seek treatment.

Sign only after you understand and agree to the above.

_____
Printed name of Patient

x_____ _____
Signature of Patient DATE

x_____ _____
Signature of Representative DATE
( if patient is a minor or is handicapped)

x_____ _____
Witness to Patient's Signature DATE

turn over →

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**Dr. J.B. Marinacci**
**3 Station Place Way Hurricane, WV 25526**
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## PATIENT FINANCIAL RESPONSIBILITY

You are ultimately responsible for any charges incurred in this office. It is your legal responsibility to pay and deductible amount, co-insurance, and or any other balances not paid by your insurance carrier. Your signature on this document indicates that you agree to pay for any outstanding charges incurred in this office.

Patients that do have health insurance:

We will check your benefits as a courtesy but what your insurance may tell us might differ when we actually bill them
**YOU** are responsible to check your chiropractic benefits prior to your visit.

Patients that do not have health insurance:

Payment is due on the day of service.

We will strive to work out s feasible payment option for anyone who is need of care. Unless other prior written agreements have been made, any outstanding balance more than 60 days old is considered delinquent.

*I authorize payment of insurance benefits directly to Teays Valley Chiropractic. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, collection agencies, and payers to secure the payment of benefits or inform them of concurrent treatment. By signing below I indicate that I have read, understood, and agree with the terms on this page.*

_____ _____

*Signature of responsible party ( Parent of Legal Guardian)* *DATE*