NEW PATIENT REGISTRATION & FINANCIAL POLICY

Life Wellness Centre

FINANCIAL POLICY

Thank you for choosing Life Wellness Centre to assist you in achieving and maintaining your health and well-being. We are committed to your successful treatment. We feel that everyone benefits when there is a definite and clear financial agreement prior to treatment. In an effort to maintain the highest level of professional care possible, we have established the following as our financial policy, which we require you to read and sign before receiving treatment: *Full payment is due at time of service. We accept cash, checks, and all major credit cards.*

REGARDING INSURANCE

We do not accept insurance assignment. We request that our fees be paid in full on your first visit and each visit thereafter. We do not participate in managed care or preferred provider organizations. We do not promise that any insurance company will pay our fees as charged to you. You must clearly understand and agree that you are charged directly and are personally responsible for all services rendered to you in our office. As a service to you, our office will complete any necessary reports and forms to help you collect from your insurance company.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of your insurance company's determination of usual and customary rates.

MINOR PATIENTS

The adult accompanying a minor and the parents (or guardian) are responsible for full payment.

CANCELLATION POLICY

Life Wellness Centre requires a 48-hour notification of appointment cancellation. If this notification is not received, by signing below you understand and agree that you will be charged for the entire scheduled appointment fee and billed immediately. Thank you for reviewing our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. My signature below indicates that I both understand and agree to this Financial Policy. The amount will not be billed to any insurance company.

_____	_____
Name of Patient (Please Print)	Date
_____	_____
Signature of Patient/Responsible Party	Date
_____	_____
Witness	Date

NEW PATIENT REGISTRATION FORM
(ALL INFORMATION IS CONFIDENTIAL)

Life Wellness Centre

PERSONAL

First Name : _____ **Last Name :** _____

Pronoun Preferance : _____

Address : _____

City : _____ **State :** _____ **ZIP :** _____

Home Phone : _____ **Cell Phone :** _____

Work Phone : _____ **Email :** _____

Date of Birth : ____/____/_____ **Sex : M F** (circle one) **Marital Status : S M D W** (circle one)

EMPLOYMENT

Occupation : _____

Employer : _____

Referred By : _____

Emergency Contact : _____

Emergency Contact Phone Number : _____

Work Phone : _____ **Email :** _____

Date of Birth : ____/____/_____ **Sex : M F** (circle one) **Marital Status : S M D W** (circle one)

Spouse's Name / Significant Other (If applicable) : _____

Is your condition due to an auto accident or job-related injury : _____ **Yes** _____ **No**

Are you covered by Medicare? : _____ **Yes** _____ **No**

_____

Signature of Patient or Guardian

_____

Date

PATIENT HEALTH HISTORY

Life Wellness Centre

1. Reason for consulting this office:

_____

_____

_____

_____

2. Have you ever had previous chiropractic care? : _____ **Yes** _____ **No**

Name of Doctor : _____ **Date/s of care :** ____/____/_____

3. Describe Complaints and symptoms: (please be specific)

Involving neck and head: _____

_____

Involving mid-back/shoulders/arms,hands: _____

_____

Involving low back/hips/legs/knees : _____

_____

Check which most accurately describes your condition :

Your complaints/ symptoms:	Come/go ☐	*Come on gradually* ☐	*Come on suddenly* ☐

Symptoms have persisted for:	*Hours* ☐	*Days* ☐	*Weeks* ☐	*Months* ☐	*Years* ☐

Symptoms are **better** in:	*AM* ☐	*Midday* ☐	PM ☐
Symptoms are **worse** in:	*AM* ☐	*Midday* ☐	PM ☐

Do not change with time of day : *Check Here* ☐

What activities make condition worse? : _____

What activities make condition better? : _____

PATIENT HEALTH HISTORY

Life Wellness Centre

Please check the following activities that are related to your present complaint.

Balancing ☐	Bending Over ☐	Coughing or sneezing ☐
Getting in/out of car ☐	Kneeling ☐	Lying flat on stomach ☐
Lying on side, knees bent ☐	*Pushing* ☐	Sitting at table ☐
Sleeping ☐	*Turning over in bed* ☐	*Dressing Self* ☐
Bending forward to brush teeth ☐	*Climbing* ☐	*Lying on back* ☐
Gripping ☐	Reaching ☐	Sitting at computer ☐
Pulling ☐	*Waklking Short Distance* ☐	*Standing > 1 hour* ☐

Other : _____

_____

Please check the following activities that are related to your present complaint.

Blurring Vision ☐	Headaches ☐	*<- if so, how often?* _____
Dizziness ☐	Loss of sleep ☐	Low immunity ☐
Depression ☐	*Numbness* ☐	Buzzing / Ringing in ears ☐
Paralysis ☐	*Muscle twitching/ spasm* ☐	Confusion ☐
Convulsions ☐	Difficulty sitting at a table ☐	*Nausea* ☐

Other : _____

_____

PATIENT HEALTH HISTORY

Life Wellness Centre

4. Occupation.

How many hours a week do you spend at work? : _____

How many of those hours are spent sitting? _____ *Standing?* _____ *Moving about?* _____

Does your work require telphone usage? _____ Yes _____ No _____ # of hours

Do you use a headset or hands-free ear jack? _____ Yes _____ No

Does your work require lifting or carrying objects over 10 pounds? _____ Yes _____ No

If so, how many hours a day do you do this type of work? _____

5. Do you currently exercise? : _____ **Yes** _____ **No**

If yes, what type of exercise? _____

_____

How frequently? _____

6. Do have any prior experience with Yoga? : _____ **Yes** _____ **No**

If yes, what type? _____

_____

7. Please list any significant health problems or diseases you have presently or have had :

_____

_____

_____

_____

8. Do your wear orthotics ? : _____ **Yes** _____ **No**

Have you previously worn orthotics? : _____ **Yes** _____ **No**

If yes, for how long? _____

9 . List all injuries you have had (i.e minor ones, childhood falls, contact sports, broken bones, etc.)

Date	**Injury**
_____ /_____ /_____	_____
_____ /_____ /_____	_____
_____ /_____ /_____	_____
_____ /_____ /_____	_____

PATIENT HEALTH HISTORY

Life Wellness Centre

10 . List all auto accidents you have had.

Date	Accident
_____ /_____ /_____	_____
_____ /_____ /_____	_____
_____ /_____ /_____	_____
_____ /_____ /_____	_____

11 . List all surgical operations you have had.

Date	Operation
_____ /_____ /_____	_____
_____ /_____ /_____	_____
_____ /_____ /_____	_____
_____ /_____ /_____	_____

12. List medications you are taking and for what condition. :

Medication	Condition
_____	_____
_____	_____
_____	_____
_____	_____

13. (Women Only) Are you pregnant ? : _____ **Yes** _____ **No**

Start date of last menstrual cycle : _____/_____/_____

14. What are your goals regarding health and wellness?

_____

_____

_____

_____