Life Wellness Centre

New Patient Registration & Financial Policy

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

Life Wellness Centre
13455 Sunrise Valley Drive, Suite 300, Herndon, VA 20171
571-643-0255 www.lifewellnesscentre.com

New Patient Registration Form

(All information is confidential)

Personal

First Name: _____ Last Name: _____

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: _____

Nearest Relative/Emergency Contact: _____

Contact Phone#: _____

Spouse's Name: _____

Is your condition due to an auto accident or job-related injury? ____ Yes ____ No

Are you covered by Medicare? ____ Yes ____ No

_____
Patient's or Guardian's Signature

_____
Date

Patient Health History

1. Reason for consulting this office: (please be specific)

_____
_____
_____
_____

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, feet: _____
_____

Circle which most accurately describes your condition:

Complaints/symptoms: Come/go Came on gradually Came on suddenly
Symptoms have persisted for: Hours 1 Day Days Weeks Months Years
Symptoms are **better** in: AM Midday PM
Symptoms are **worse** in: AM Midday PM
Do not change with the time of day

What activities make condition **worse** ? _____

What activities make condition **better** ? _____

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

___Balancing
___Getting in or out of a car
___Lying on side, knees bent
___Sleeping
___Bending forward to brush teeth
___Gripping
___Pulling
___Standing > 1 hour
___Bending over
___Kneeling
___Pushing
___Turning over in bed
___Climbing
___Reaching
___Walking short distance
___Coughing or sneezing
___Lying flat on stomach
___Sitting at a table
___Dressing self
___Lying on back
___Sitting at computer
___Other_____
_____

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

___Blurring vision
___Dizziness
___Numbness
___Buzzing or ringing in ears
___Confusion
___Headaches (How often? _____)
___Loss of sleep
___Paralysis
___Convulsions
___Low immune resistance
___Sitting at a table
___Depression
___Muscle twitching
___Other_____

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 telephone usage? ___Yes ___No If so, how many hours? _____
Do you have a head set or hands-free ear jack? ___Yes ___No
Does your work require lifting or carrying packages or equipment over ten 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. List significant health problems or diseases you have had:
_____
_____
_____
_____

7. Do you wear orthotics? ___Yes ___No; Have you previously worn orthotics? ___Yes ___No
How long ago did you wear them?_____

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

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

9. List all auto accidents you have had:

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

10. List all surgical operations you have had:

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

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

Medication	**Condition**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Children Only:

Date	**Immunization**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

12. (Women only) Are you pregnant? ____ Yes ____ No

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

13. Family History: (for example cancer, diabetes, heart problems, scoliosis, back or neck problems, etc.)
Father:_____
_____

Mother:_____
_____

Brother/s:_____
_____

Sister/s:_____
_____

14. What are your goals regarding your health and wellness?
_____
_____
_____
_____
_____
_____