



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:

- | | | |
|---|---|--|
| <input type="checkbox"/> Balancing | <input type="checkbox"/> Bending over | <input type="checkbox"/> Coughing or sneezing |
| <input type="checkbox"/> Getting in or out of a car | <input type="checkbox"/> Kneeling | <input type="checkbox"/> Lying flat on stomach |
| <input type="checkbox"/> Lying on side, knees bent | <input type="checkbox"/> Pushing | <input type="checkbox"/> Sitting at a table |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Turning over in bed | <input type="checkbox"/> Dressing self |
| <input type="checkbox"/> Bending forward to brush teeth | <input type="checkbox"/> Climbing | <input type="checkbox"/> Lying on back |
| <input type="checkbox"/> Gripping | <input type="checkbox"/> Reaching | <input type="checkbox"/> Sitting at computer |
| <input type="checkbox"/> Pulling | <input type="checkbox"/> Walking short distance | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Standing > 1 hour | | _____ |

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

- | | | |
|---|---|--|
| <input type="checkbox"/> Blurring vision | <input type="checkbox"/> Headaches (How often? _____) | <input type="checkbox"/> Low immune resistance |
| <input type="checkbox"/> Dizziness | | <input type="checkbox"/> Sitting at a table |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Buzzing or ringing in ears | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Muscle twitching |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Convulsions | <input type="checkbox"/> 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

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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?
