Colarusso Family Chiropractic!

Chiropractic Registration Information

Date:_____ Legal Name:_____ Preferred Name:_____

Address:_____ City:_____ State:____ Zip:_____

Preferred form of Contact: ☐Cell ☐Home☐Work May we contact you at work?_____

Phone:(C):_____(H):_____(W):_____

Email:_____ Want to receive our Newsletter?_____

Date of Birth:___/___/____ Age:_____ Sex: Male/Female Are you Pregnant? Yes No

Marital Status:☐Single ☐Married ☐Widowed☐Separated☐Divorced

Work Status:☐Employed ☐Unemployed ☐Student ☐Retired Social Security #:_____

Occupation:_____ Employer:_____

Employer Address:_____ City:_____ State:___ Zip:_____

Spouse's Name:_____ Spouse's Employer/Occupation:_____

Whom may we thank for referring you?_____

In Case of an Emergency, whom may we contact?

Name:_____ Phone:_____ Relationship:_____

Payment is Expected at the Time of Service

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that the office of Dr. John J. Colarusso will prepare any necessary reports and forms to assist me in making collection from the insurance company. I also understand that any amount authorized to be paid directly to Dr. John J. Colarusso will be credited upon receipt, however, I clearly understand and agree that any services rendered are charged directly to me and I am personally responsible for payment of my account in full. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable.

Patient or Guardian's Signature: _____ Date___/___/_____

Patient Condition

Reasons for Visit: _____

_____

When did your symptoms first appear? _____

Is your condition getting ☐Worse ☐Better ☐Staying the Same

Use the letters below to indicate the type and location of your complications. Next to the letter, rate the severity of your symptoms from 1 (least) to 10 (severe). i.e. S/7

A-Achy B-Burning

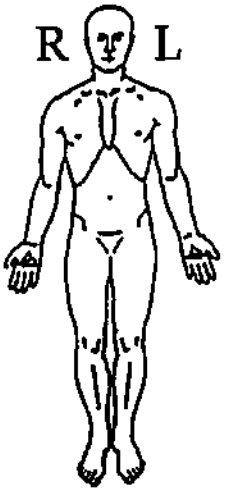
D-Dull N-Numbness

S-Shooting T-Tingling

P-Pain ST- Stiffness

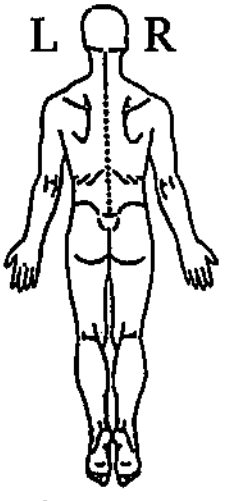
SH-Sharp SR-Soreness

TH- Throbbing O-Other: _____



How often do you have this pain? _____

Other symptoms (Check all that apply):



☐ Headache	☐ Nervousness	☐Head Seems Heavy
☐ Loss of Balance	☐ Fatigue	☐Depression
☐ Diarrhea	☐ Upset Stomach	☐Light Sensitivity
☐ Constipation	☐ Cold Hands/Feet	☐Memory Difficulty
☐ Ears Ringing	☐ Irritability	☐Difficulty Sleeping
☐ Fainting	☐ Tension/Stress	☐Pins & Needles

Your pain interferes with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation

Other: _____

What makes it better? _____

What makes it worse? _____

What are your favorite activities? _____

Health History

What treatment(s) have you already tried for your condition? None☐ Medication ☐

☐Surgery ☐ Physical Therapy ☐Other_____

Describe treatment and results_____

Have you previously seen a chiropractor? No☐ Yes,☐ when and for what condition?

_____

Names of doctors who have treated your condition. _____

Current medications (Including non-prescription): _____

_____

Please list any significant injuries or surgeries you have had. _____

_____

Other Concerns that are not listed? _____

Check Mark "☐" to indicate if you have had any of the following:

☐Allergy Shots

☐Anemia

☐Appendicitis

☐Arthritis

☐Asthma

☐Cancer

☐Diabetes Type 1☐ Type 2☐

☐Depression

☐Emphysema

☐Epilepsy

☐ Fractures
☐ Gout
☐ Heart Disease
☐ Hepatitis
☐ Hernia
☐ Herniated Disk
☐ High Cholesterol
☐ Migraines
☐ Osteoporosis
☐ Pacemaker

☐ Polio

☐ Rheumatoid

☐ Scoliosis

☐ Stroke

☐ Thyroid Problems

☐ Tuberculosis

☐ Tumors/Growths

☐ Ulcers

☐ Other_____

_____

Habits	None	Light	Moderate	Heavy
Alcohol	o	o	o	o
Coffee	o	o	o	o
Tobacco	o	o	o	o
Recreational Drugs	o	o	o	o
Exercise	o	o	o	o
Sleep	o	o	o	o
Appetite	o	o	o	o
Soft Drinks	o	o	o	o
Water	o	o	o	o
Salty Foods	o	o	o	o
Sugary Foods	o	o	o	o
Artificial Sweeteners	o	o	o	o

Office Policies & Procedures Agreement

Financial Arrangements and Policies

I understand and agree that health and accident insurance policies are an arrangement between an insurance company carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to pe paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Insurance Billing/ Payment

Patients are ultimately fully responsible for products purchased and services provided by our office. Our office is a participating provider with a number of insurance companies. For your convenience, our office will make an effort to verify your insurance benefits. However, ultimately, it's the patient's responsibility to determine benefits and authorization information before services are rendered. Please note that verification of benefits is not a guarantee of benefits. Your insurance company makes the final determination of insurance benefits when they consider the claim. It is understood that despite our best efforts to provide you with a financial estimate of the cost of case, times arise when insurance companies do not reimburse what was originally quoted. Patients are fully responsible for payment of products and services not authorized or covered by their insurance company. If a referral is required but not provided at the time of your visit, full payment is expected at the time of service. Your signature below will give power of attorney to endorse checks made to John J. Colarusso, D.C., to be credited to your account.

Payment Arrangements

We understand that occasions arise when it may be necessary for you to request to be billed rather than pay at the time of service. This may include setting up a payment plan for those who may require extensive treatment. Payment is due within 30 days of the service rendered. Bills that are delinquent more than sixty (60) days will be transferred to an outside collection agency unless prior arrangements have been made. Patients will be responsible for collection and/or attorney's fees for all such disputes which can be up to 50% of your balance. For any unpaid balances, that are 60 days past due, a monthly feel of 1.5% will be added to your balance. If there are legitimate problems, please discuss them prior to the sixty (60) days so we may find a workable solution.

Appointment Policy

It is our goal to provide the best care for all of our patients in a time effective environment. Because of this dedication to our patients, we require 24-hour notice if you are unable to make your scheduled appointment. Failure to give this notice will result in a $35.00 cancellation/ no show fee. We understand that emergencies happen and you may not have control over missing your appointment. We reserve the right to decide if this fee will be put in place.

Informed Consent to Chiropractic & Acupuncture Care

I request and consent to the performance of chiropractic examination, adjustment/ manipulation, Acupuncture/ Acupressure, and any and all other chiropractic procedures permitted by out State Law of Utah. This includes medical records review, various modes of physiotherapy and necessary diagnostic x-rays on myself (or on the patient named below, for whom I am legally responsible) by any of the treating doctors of chiropractic on staff and / or any licensed chiropractor deemed appropriate by our office. I understand that results of the treatment are not guaranteed. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are associated risks with treatment, although rare, including, but not limited to, fracture, disc injuries, strokes, dislocations, strains, and worsening symptoms. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels and the time, based on the facts then known, and is in my best interest. This consent form covers the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Records Release Authorization & Permission for Clinical Research

I hereby grant permission for John J. Colarusso, D.C., to release any information pertaining to diagnosis and treatment of myself and care in this and other offices to my primary care physician, or to any other physician or therapist whom I am currently or previously under care with. I further authorize this office to utilize information pertaining to my care for the purpose of the clinical research, publication and education purposes, including the use of treatment records, and videotaping of my treatment and management in this and other offices for the exclusive study of other doctors. I realize the necessity of such purposed and understand that the highest ethical standards will be maintained in maintaining patient confidentiality. In accordance with all stated above, I hereby understand and agree to the above stated office policies.

Print Patient's Name:_____

Signature of Patient:_____ Date:__/__/____

Signature of Parent or Guardian:_____ Date:__/__/____

Assignments of Proceeds, Contractual Lien, and Authorization
(Financial Agreement)

I herby direct any and all insurance carriers, agencies, attorneys, governmental departments, companies, individuals, and/or other legal entities (payers), which may elect or be obligated to pay benefits to me for any medical conditions. Accidents. Injuries, or illnesses, past or future (condition), to pay directly to, and exclusively in the name of Dr. John Colarusso such sums as may be owing to Dr. John Colarusso for charges incurred by me, including but not limited to, charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at the office of Dr. John Colarusso. I further grant contractual lien to Dr. John Colarusso with respect to my charges, applicable to all payers, however, I understand that nothing in the agreement shall be construed as an election by Dr. John Colarusso to claim protection under and statutory lien law. For the purposes of this agreement, "benefits" shall include, but shall not be limited to, proceeds from any settlement, judgement, or verdict, as well as any proceeds relating to commercial health or group insurance, disability benefits, worker's compensation. Medical payments benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured and underinsured motorist coverage, third-part liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits or proceeds payable to me for the purpose stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, in the event a payer refuses to pay Dr. John Colarusso, I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to Dr. John Colarusso to the extent of my charges, as well as any and all cause of action that I might have against such payer, to prosecute such cause of action either in my name or in the office's name, and settle or otherwise resolve such cause of action as the office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a letter of protection to the office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office. I further direct such attorney to provide immediate notice to the office regarding any funds received by the attorney relating to my accident, to promptly pay such office, and to provide a full accounting of such finds to the office upon its request.

I hereby direct all the payers to release to Dr. John Colarusso any information regarding any coverage or benefits which I may have including, but not limited to, the amount of coverage, the amount paid thus far, and the amount of any outstanding claims.

I authorize this office to release any information regarding my treatment if pertinent to my case(s) to all payers as defined above to facilitate collection under this agreement. I hereby direct this office to file a copy of this agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with the said payers. I hereby authorize Dr. John Colarusso to endorse/ sign my name on any and all check listing me as a payee which are presented to this office for payment of an account relating to me, my spouse. Or any of my dependents. I further authorize Dr. John Colarusso to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due to Dr. John Colarusso for his services. This agreement does not constitute any consideration for this office to await payments and it may demand payments from me immediately upon rendering services at its option. If this office must take any action to collect an outstanding balance on my account, I will be responsible for payments and will reimburse Dr. John Colarusso for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees up to 50%.

This agreement shall not be modified or revoked without mutual consent of Dr. John Colarusso and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with terms of this agreement.

I agree that each and every position of the agreement is reasonably necessary for the protection of the rights and interests of Dr. John Colarusso and myself. However, should any provisions of this agreement be found to be invalid, illegal, or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions, of this agreement, shall nevertheless, remain in full force and effect.

Patient Name (Please Print): _____

Patient Signature: _____ Date: __/__/____

Name of Custodial Parent or Legal Guardian (Please Print): _____

Parent/ Guardian's Signature: _____ Date: __/__/_____