# Confidential Patient Information

Todays Date: ______________________

## General Information

Name ______________________ Sex ________ Age ________

Address ______________________ City ____________ State ________ Zip ________

Married  Single  Divorced  Widowed  Date of Birth ______________ SSN ______________

Phones: Home ______________ Cell ______________ Cell Carrier? ______________

Email ______________________ Occupation ______________

Employer ______________________ Work # ______________

Family Phyician ______________________ Contact # ______________

How did you hear of our office? ______________________

We will send you appointment reminders, would you like EMAIL or TEXT MESSAGES? (circle one)

Are you presently under another provider's care? **Y N** Who, and for what? ______________

## Focus of Care

What are your reasons for seeking care at our office? ______________________

What was the initial cause? ______________________

When did it begin? ______________ Since onset, has it gotten better or worse? ______________

What makes it feel better? ______________________

What makes it feel worse? ______________________

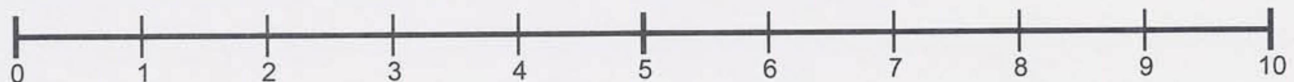
Please check any activities that have been affected:

- ☐ Work
- ☐ Sitting
- ☐ Stretching
- ☐ Relationships
- ☐ Sleep
- ☐ Standing
- ☐ Social Life
- ☐ Sexuality
- ☐ Walking
- ☐ Bending
- ☐ Recreation
- ☐ Emotions
- ☐ Other ______________________

Which are you interested in?

- ☐ Pain Relief
- ☐ Wellness Care
- ☐ Stress Relief
- ☐ Other ______________
- ☐ Preventive Care
- ☐ Postural Correction
- ☐ Athletic Performance

How committed are you to correcting this problem? (0 - Not at all, 10 - Completely)




Please list any relevant medical events (surgeries, hospitilizations, treatments, etc…) ______________________

______________________

______________________

______________________

Please list any family history of major medical conditions, illnesses or diseases ______________________

______________________

______________________

**OVER** ⟶

Please list medications and what you're taking them for________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Please list any allergies________________________________________________________________

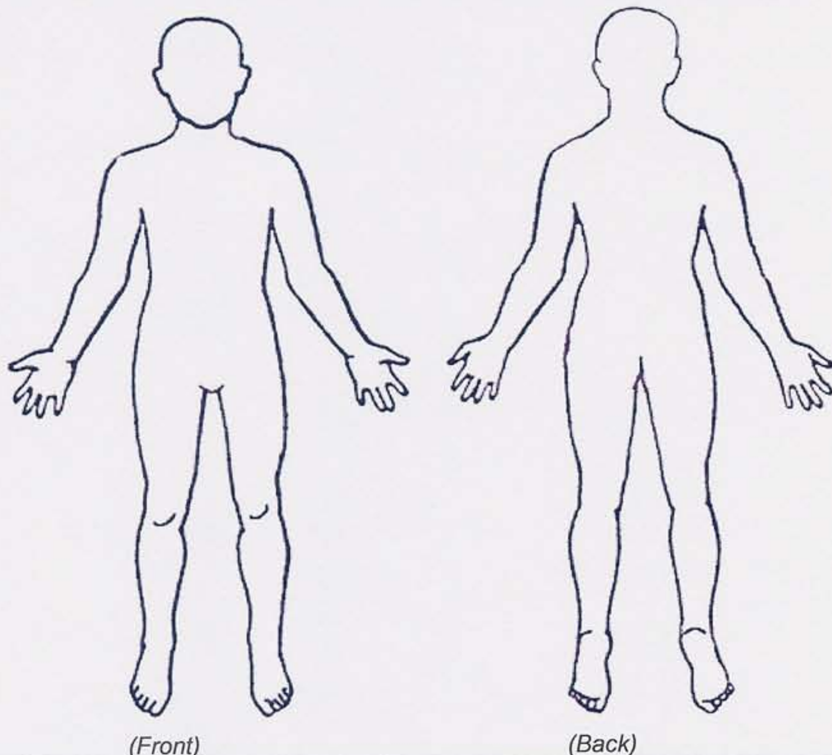
Please list supplements your are taking__________________________________________________

________________________________________________________________________________

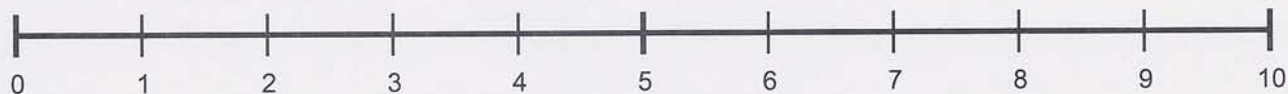
***Please mark the body locations with the symbols that most accurately describe your symptoms***

***draw/outline any radiating pain***

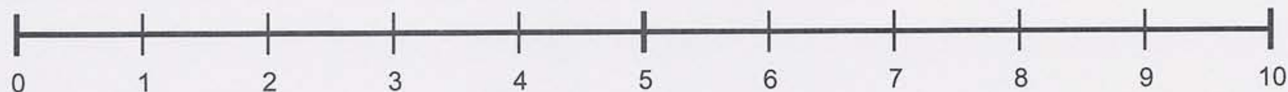
- **A - Ache**
- **B - Burning**
- **S - Stabbing**
- **N - Numbness**
- **T - Tingling**
- **P - Pins & Needles**
- **O - Other (describe below)**




How bad is your complaint on average? (0 - No Pain, 10 - Worst Imaginable)




How bad is your complaint at its worst? (0 - No Pain, 10 - Worst Imaginable)




*By signing below, I certify that the information above is true and correct and I agree to notify the doctors and staff of any changes as they occur. I authorize Life Long Wellness to obtain verification of my insurance coverage and understand that such verification is not a guarantee of payment. I understand and agree that insurance policies are an arrangement between the insurance carrier and myself. I authorize the release of any medical information necessary to process insurance claims. I also request and authorize payment of benefits either to myself or to Life Long Wellness and its affiliates if they accept assignment. I hereby authorize Life Long Wellness, its doctors and staff to perform examination and administer diagnositic examination and to render treatment as they so deem necessary.*

Printed Name____________________________________________________

Signature of Patient (or Guardian)_________________________________________

*LLW 1-26-10 JDA*

# Financial Policy

Thank you for choosing Life Long Wellness for your health care needs. We feel it is important that you be made aware of our financial policies. Please read through this carefully. If you have any questions, please ask.

## Payment for Services

Payment is ***due*** the day treatment is rendered. We accept VISA, MasterCard, cash and personal checks. To ensure proper credit while paying cash, please ask the front desk for a receipt during checkout.

## Cancellation of Appointments

We require ***24 hour notice*** when canceling appointments. Missed appointments without prior notice will result in a $25 missed appointment fee.

## Overpayments

In the event there is an overpayment on your account, a credit will be placed on the account.

## Health Insurance

Health insurance claims will be filed from our office promptly. If there is no response from your insurance company within 30 days, a bill will be sent to you. At this point, we ask that you follow-up with your insurance company to rectify the situation.

Reduction or rejection of your insurance claim **does not** relieve you of your financial obligation. Payment for services rendered to you in good faith is your responsibility. Life Long Wellness cannot guarantee coverage.

## Returned Checks

If a check is returned due to insufficient funds, we will attempt to deposit the check a second time. There is a $25 charge for each returned check.

## Finance Charges

We realize financial difficulties arise, if this becomes the case please notify us immediately. An 18% APR finance charge will be applied to all outstanding balances. All statement payments are due by the 25th of each month. A $25 late payment fee will be assessed on all late payments.

**Signature** ______________________________________________

By signing, I affirm that I have read and understand and agree to the above in which was presented to me.