Dear New Patient,

The Staff at Haymarket Chiropractic & Rehabilitation (HCR) and I are delighted that you have chosen our facility for your therapy. Our goal is to provide you with a premium level of care and a beneficial experience. If, at any point, you have questions or concerns regarding any aspect of your treatment, please feel free to call or contact me via email immediately.

Thank you again for choosing Haymarket Chiropractic. We hope to exceed your expectations.

Sincerely,

Holly Moriarty, D.C.

President/CEO

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Haymarket Chiropractic & Rehabilitation

Patient Information

Name: ____ Social Security: ______________________________

Street Address: _____________________________________ Home Phone: ________________________________

City, State, Zip: _____________________________________ Cell Phone: __________________________________

Sex: Male Female Date of Birth: ________ / ________ / ___________

Employer: ____ Work Phone: _______________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower ☐ Life Partner

Spouse/Emergency Contact Name: ________________________ Contact Number: ___________________________

Primary Care Physician or Referring Physician:____

Practice: _______________________________________ Contact Number: __________________________________

How did you hear about us? (Be specific)

- ☐ Search Engine/Website
- ☐ HPTC Staff Member __________________________________
- ☐ From an Existing Patient ______________________________
- ☐ Insurance Company ___________________________________
- ☐ Doctor/Physician ____________________________________
- ☐ Bull Run Observer
- ☐ Other ____

Insurance Information

Primary Insurance:________________________________ Subscriber's Name:_____________________________

ID #:____________________________ Group #:__________________________ Effective Date:________________

Secondary Insurance:______________________________ Subscriber's Name:_____________________________

ID #:___________________________ Group #:__________________________ Effective Date:_________________

Haymarket Chiropractic & Rehabilitation

Current Condition

Reason for today's visit? ________________________ When did your symptoms begin? ____________________

Rate the severity of your pain on a scale of 0 (no pain) to 10 (severe pain) 0 1 2 3 4 5 6 7 8 9 10

What type of pain are you experiencing? (Circle all that apply_

Sharp Dull Throbbing Tingling Stiffness Numbness Shooting Aching Burning

Does your pain radiate from one area to another? Yes No If yes, please explain:_______________________

____

Have you had this pain before? Yes No Have you received treatment for this before? Yes No

If yes, what did the previous treatment consist of (medications, surgery, etc)?_________________________________

____

Health History

Please list any previous surgeries, fractures or breaks, falls, head injuries, or other illnesses you have had

Date	Type of surgery/injury/illness	Date	Type of surgery/injury/illness

Please mark "Yes" or "No" to indicate if you have had any of the following:

Aids/HIV	Yes	No	Goiter	Yes	No	Pinched Nerve	Yes	No
Alcoholism	Yes	No	Gonorrhea	Yes	No	Pneumonia	Yes	No
Allergy Shots	Yes	No	Gout	Yes	No	Polio	Yes	No
Anemia	Yes	No	Heart Disease	Yes	No	Prostate Problem	Yes	No
Anorexia	Yes	No	Hepatitis	Yes	No	Prosthesis	Yes	No
Appendicitis	Yes	No	Hernia	Yes	No	Psychiatric Care	Yes	No
Arthritis	Yes	No	Herniated Disk	Yes	No	Rheumatoid	Yes	No
Asthma	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Bleeding	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Breast Lump	Yes	No	High Blood Pressure	Yes	No	Stroke	Yes	No
Bronchitis	Yes	No	Kidney Disease	Yes	No	Suicide Attempt	Yes	No
Bulimia	Yes	No	Liver Disease	Yes	No	Thyroid Problems	Yes	No
Cancer	Yes	No	Measles	Yes	No	Tonsilitis	Yes	No
Cataracts	Yes	No	Migraine	Yes	No	Tuberculosis	Yes	No
Chemical Depend.	Yes	No	Miscarriage	Yes	No	Tumors, Growths	Yes	No
Chicken Pox	Yes	No	Mononucleosis	Yes	No	Typhoid Fever	Yes	No
Diabetes	Yes	No	Multiple Sclerosis	Yes	No	Ulcers	Yes	No
Emphysema	Yes	No	Mumps	Yes	No	Vaginal Infections	Yes	No
Epilepsy	Yes	No	Osteoporosis	Yes	No	Venereal Disease	Yes	No
Fractures	Yes	No	Pacemaker	Yes	No	Whooping Cough	Yes	No
Glaucoma	Yes	No	Parkinson's	Yes	No	Other	____________	

Please list all medications you are currently taking (prescription & over the counter)

Medication	Dosage	Medication	Dosage

Haymarket Chiropractic & Rehabilitation

Payment Policy

1. Insurance: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. **If your insurance coverage changes, please notify us before your next visit** so we can make the appropriate changes to help you receive your maximum benefits. **You are fully responsible for understanding your insurance policy and coverage.**
2. Referrals: If your insurance requires a referral for a specialist, it is your responsibility to provide us with the referral dated the day of your first visit from your Primary Care Physician (PCP). We are not able to request a referral from your PCP or insurance. If you do not have the referral at the time of your visit, your appointment will be rescheduled until we have the referral. If you are unsure if you require a referral or have any other questions concerning your insurance, we suggest you contact your insurance company. **Knowing your insurance benefits is your responsibility.**
3. Co-Payments and Deductibles: All co-payments and deductibles must be paid **at the time of service.** This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles from patients can be considered fraud.
4. Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claim paid. If your insurance company needs you to supply certain information directly, it is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. **If your insurance company does not pay your claim within 60 days, the balance will be automatically billed to you.** Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.
5. Collections: Unpaid balances will be sent to collections. If your balance is sent to collections, you will be responsible for 33% of your balance in addition to the original amount sent to collections.

I have read and understand the above statements.

______________________________ ____________

Printed Name of Patient Date

______________________________ ____________ ______________________

Signature of Patient/Patient's Guardian Date Relationship to Patient (if patient is minor)

Assignment of Benefits Authorization

I certify that I, and/or my dependent(s), have insurance coverage with ______________________ (insurance company). I assign directly to Haymarket Chiropractic and Rehabilitation, PC and/or Virginia Sports Chiropractic, PC, all insurance benefits, if any, otherwise payable to me for services rendered. ***I understand that I am financially responsible for all charges whether or not paid by insurance.*** *I authorize the use of my signature on all insurance submissions. I also authorize release of medical information relevant to these services when required by Health Care Financing Administration (HCFA), its agents, or insurance carriers for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.*

I have read and understand the above statements.

______________________________ ____________

Printed Name of Patient Date

______________________________ ____________ ______________________

Signature of Patient/Patient's Guardian Date Relationship to Patient (if patient is minor)

Haymarket Chiropractic & Rehabilitation

Notice of Privacy Practices

I acknowledge that I have been given Haymarket Chiropractic's Notice of Privacy Practices. I understand that if I have any questions or complaints, I may contact the facility.

Patient's Name (Printed):_____________________________ Date: ____________

Patient's Signature: ________________________________ Date: ____________

Parent/Guardian Signature: ___________________________ Date: ____________
(if patient is a minor)

Missed, Cancelled, Rescheduled Appointments Policy

Patients will be charged $35 for missed appointments and for appointments **cancelled OR rescheduled within the 24 hours preceding the appointment**. This means if the patient calls the day of his/her appointment and reschedules the appointment to a different time of that same day, there will be a $35 fee enforced. We need at least 24 hours notice to be able to fill **any** open appointment cancelled or rescheduled by patients. The charges will be your responsibility and must be paid prior to your next visit.

If you are 15 or more minutes late for your appointment, we will not be able to treat you at that time. In order for all of our patients to receive quality treatment and attentiveness from the providers, the treatment schedules are very time sensitive. Patients will be charged $35 if they are 15 or more minutes late for an appointment.

I have read and understand the above statements.

________________________________ ____________
Printed Name of Patient Date

________________________________ ____________ ________________________
Signature of Patient/Patient's Guardian Date Relationship to Patient (if patient is minor)

Appointment Reminders

Due to patient request, we have signed up for a reminder service that will automatically inform our patients of their appointment dates and times. This reminder will be sent through email and/or text message.
You will automatically receive text message reminders. If the text message reminders are unwanted, you will be given the option to unsubscribe when you receive your first text message from us. For e-mail reminders, you will be e-mailed a welcome e-mail where you must either opt in (if you do want e-mail reminders) or opt out (if you do not want e-mail reminders).

Patient Name: ________________________________

Email: ________________________________ Cell Number: ___________________________

Your information will not be distributed to any third parties.

Signature: ________________________________ Date: ____________

Haymarket Chiropractic & Rehabilitation

Consent to Treat

Patient's Name: ____

I have been informed of the nature of my disorder(s) and of the nature and purpose of Chiropractic/Physical Therapy procedures proposed as treatment. I have also been informed of the possible consequences and risks inherent in such treatment. The availability of alternate treatment options has been explained to me. I have also been advised of the possible consequences if I decide not to receive care. I understand that there is no guarantee or warranty for any specific cure or result.
The welcome package / information package and all data from Haymarket Chiropractic Rehabilitation and Virginia Sports Chiropractic of Warrenton may be used for health, information, and billing purposes interchangeably between these different office locations if necessary.

I have read the above statements and I understand the information provided. I therefore authorize this clinic to proceed with Chiropractic care and treatment.

Patient's Signature: _______________________________________ Date: _______________

Please complete the following if the patient is *a minor or unable to consent.*

Name of person legally authorized to sign for this patient: ______________________________
Relationship to patient: __________________

Signature of authorized person: ______________________________ Date: ______________