SHIPLEY CHIROPRACTIC
2292 West Magee Road, Suite 170
Tucson, AZ 85742
Phone (520) 797-2922
Fax (520) 742-0732

CONFIDENTIAL PATIENT INTAKE FORM

Is today's appointment concerning: ☐ Wellness ☐ Specific Symptom ☐ Auto Accident
☐ Workman's Compensation ☐ Other: _____

Patient Name _____ Birth Date _____

Martial Status: M S W D How many children? _____ Social Security Number _____

E-mail _____ Home Phone _____ Cell Phone _____

Address _____ City/State/Zip _____

How did you hear about us? _____

Have you been to a Chiropractor before? ____YES ____NO What is your: Height _____ Weight _____

Occupation _____ Employer _____ Office Phone _____

Primary insureds Name _____ **Birth Date** _____

Name of Wife or Husband _____ Insureds Social Security No _____

Insureds Employer _____ Occupation _____

Patient's Emergency Contact _____

Address _____ Phone # _____

Name and phone no. of Primary Care Doctor:

_____

_____

PAYMENT IS EXPECTED AT THE TIME OF VISIT!

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Shipley Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Shipley Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered 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.

Patient Signature _____ Date: _____

Guardian or Spouse's Signature _____ Date _____

1. How would you rate your overall Health?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. What type of exercise do you do?
☐ Strenuous ☐ Moderate ☐ Light ☐ None

3. Indicate if you have any immediate family members with any of the following:
☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus ☐ ALS ☐ Heart Problems ☐ Cancer
☐ Other_____

4. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
☐	☐ Headaches	☐	☐ Chronic Sinusitis	☐	☐ Visual Disturbances
☐	☐ Neck Pain	☐	☐ High Blood Pressure	☐	☐ Dizziness
☐	☐ Upper Back Pain	☐	☐ Heart Attack	☐	☐ Diabetes
☐	☐ Mid Back Pain	☐	☐ Chest Pains	☐	☐ Excessive Thirst
☐	☐ Low Back Pain	☐	☐ Stroke	☐	☐ Frequent Urination
☐	☐ Shoulder Pain	☐	☐ Angina	☐	☐ Smoking/Tobacco Use
☐	☐ Elbow/Upper Arm Pain	☐	☐ Kidney Stones	☐	☐ Drug/Alcohol Dependence
☐	☐ Wrist Pain	☐	☐ Kidney Disorders	☐	☐ Allergies
☐	☐ Hand Pain	☐	☐ Bladder Infection	☐	☐ Depression
☐	☐ Hip Pain	☐	☐ Painful Urination	☐	☐ Systemic Lupus
☐	☐ Upper Leg Pain	☐	☐ Loss of Bladder Control	☐	☐ Epilepsy
☐	☐ Knee Pain	☐	☐ Prostate Problems	☐	☐ Dermatitis/Eczema/Rash
☐	☐ Ankle/Foot Pain	☐	☐ Abnormal Weight Gain/Loss	☐	☐ HIV/AIDS
☐	☐ Jaw Pain	☐	☐ Loss of Appetite		
☐	☐ Joint Pain/Stiffness	☐	☐ Abdominal Pain	**For Females Only**	
☐	☐ Arthritis	☐	☐ Ulcer	☐	☐ Birth Control Pills
☐	☐ Rheumatoid Arthritis	☐	☐ Hepatitis	☐	☐ Hormonal Replacement
☐	☐ Cancer	☐	☐ Liver/Gall Bladder Disorder	☐	☐ Pregnancy
☐	☐ Asthma	☐	☐ General Fatigue		
☐	☐ Chronic Sinusitis	☐	☐ Muscular Incoordination		

Others not listed:

5. List all prescription medications you are currently taking:

6. List all of the over-the-counter medications you are currently taking:

7. List all the supplements you are currently taking:

8. List all surgical procedures you have had:

9. What activities do you do at work?

☐ **Sit:**	☐ Most of the day	☐ Half the day	☐ A little of the day
☐ **Stand:**	☐ Most of the day	☐ Half the day	☐ A little of the day
☐ **Computer work:**	☐ Most of the day	☐ Half the day	☐ A little of the day
☐ **On the phone:**	☐ Most of the day	☐ Half the day	☐ A little of the day

10. What activities do you do outside of work?

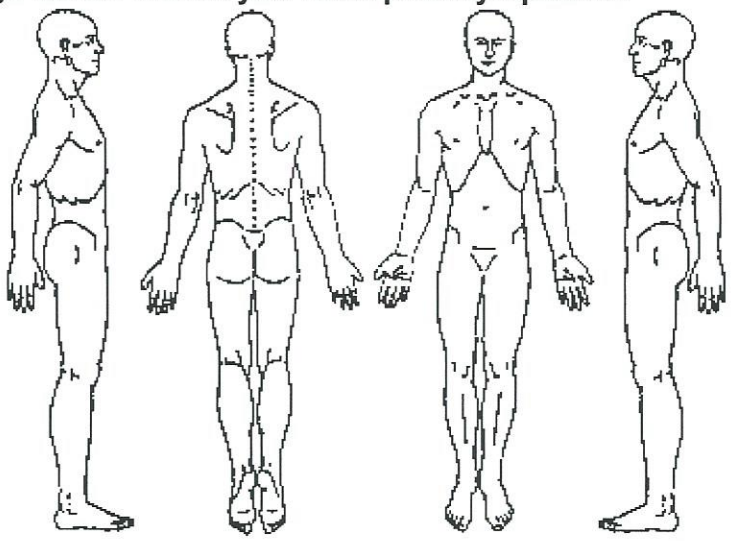
11. Have you ever been hospitalized? ☐ No ☐ Yes
If yes, why _____

12. Have you seen a chiropractor before? ☐ No ☐ Yes
If yes, do you remember how long ago? _____
If yes, what were your results? (great, good, mixed, etc) _____

13. Have you had significant past trauma? ☐ No ☐ Yes
If yes, explain: _____

14. Anything else pertinent to your visit today? _____

Indicate on the drawings below where you have pain/symptoms:



HEADACHES:

(Initial here (_____) if this section DOES NOT apply, go to the next section)

Where is the pain?
☐ Left Front ☐ Left Side ☐ Left back ☐ General ☐ Front ☐ Back/Base of head
☐ Right Front ☐ Right Side ☐ Right back

How often do you experience your symptoms?
☐ Constantly (76-100% of the time) ☐ Frequently (51-75% of the time)
☐ Occasionally (26-50% of the time) ☐ Intermittently (1-25% of the time)

How would you describe the pain?
☐ Sharp ☐ Numb ☐ Stiff ☐ Sharp with motion ☐ Shooting with motion
☐ Dull ☐ Tingly ☐ Stabbing with motion ☐ Electric-like with motion
☐ Diffuse ☐ Achy ☐ Burning ☐ Shooting ☐ Other _____

How are your symptoms changing with time?
☐ Getting Worse ☐ Staying the same ☐ Getting better

Using a scale from 0-10 (10 being the worst) how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 *(Please circle)*

How much has the problem interfered with your work activities?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How much has the problem interfered with your social activities?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Who else have you seen for your problems?
☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER Physician
☐ Orthopedist ☐ Massage Therapist ☐ Physical Therapist ☐ No one
☐ Other _____

How long have you had this problem?_____ **Do you know the date it began?** _____

How do you think your problem began?

_____

Do you consider this problem to be severe?
☐ Yes ☐ Yes, at times ☐ No

What aggravates your problem?

_____

What alleviates the problem?

_____

What concerns you the most about your problem; what does it prevent you from doing?

_____

NECK:

(Initial here (_____) if this section DOES NOT apply, go to the next section)

Where is the pain?

☐ Left side ☐ Upper Left ☐ Lower Left ☐ Entire neck ☐ Upper neck ☐ Lower neck
☐ Right side ☐ Upper Right ☐ Lower Right

How often do you experience your symptoms?

☐ Constantly (76-100% of the time) ☐ Frequently (51-75% of the time)
☐ Occasionally (26-50% of the time) ☐ Intermittently (1-25% of the time)

How would you describe the pain?

☐ Sharp ☐ Numb ☐ Stiff ☐ Sharp with motion ☐ Shooting with motion
☐ Dull ☐ Tingly ☐ Stabbing with motion ☐ Electric-like with motion
☐ Diffuse ☐ Achy ☐ Burning ☐ Shooting ☐ Other _____

How are your symptoms changing with time?

☐ Getting Worse ☐ Staying the same ☐ Getting better

Using a scale from 0-10 (10 being the worst) how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 *(Please circle)*

How much has the problem interfered with your work activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How much has the problem interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Who else have you seen for your problems?

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER Physician
☐ Orthopedist ☐ Massage Therapist ☐ Physical Therapist ☐ No one
☐ Other _____

How long have you had this problem?_____ **Do you know the date it began?** _____

How do you think your problem began?

_____

Do you consider this problem to be severe?

☐ Yes ☐ Yes, at times ☐ No

What aggravates your problem?

_____

What alleviates the problem?

_____

What concerns you the most about your problem; what does it prevent you from doing?

_____

UPPER BACK/SHOULDER:

(Initial here (_____) if this section DOES NOT apply, go to the next section)

Where is the pain?

☐ Left side ☐ Center ☐ Right side ☐ Entire upper back

How often do you experience your symptoms?

☐ Constantly (76-100% of the time) ☐ Frequently (51-75% of the time)
☐ Occasionally (26-50% of the time) ☐ Intermittently (1-25% of the time)

How would you describe the pain?

☐ Sharp ☐ Numb ☐ Stiff ☐ Sharp with motion ☐ Shooting with motion
☐ Dull ☐ Tingly ☐ Stabbing with motion ☐ Electric-like with motion
☐ Diffuse ☐ Achy ☐ Burning ☐ Shooting ☐ Other _____

How are your symptoms changing with time?

☐ Getting Worse ☐ Staying the same ☐ Getting better

Using a scale from 0-10 (10 being the worst) how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 *(Please circle)*

How much has the problem interfered with your work activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How much has the problem interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Who else have you seen for your problems?

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER Physician
☐ Orthopedist ☐ Massage Therapist ☐ Physical Therapist ☐ No one
☐ Other _____

How long have you had this problem?_____ **Do you know the date it began?** _____

How do you think your problem began?

_____

Do you consider this problem to be severe?

☐ Yes ☐ Yes, at times ☐ No

What aggravates your problem?

_____

What alleviates the problem?

_____

What concerns you the most about your problem; what does it prevent you from doing?

_____

ARM:

(Initial here (_____) if this section DOES NOT apply, go to the next section)

Where is the pain?

☐ Entire Left Arm ☐ Upper Left ☐ Lower Left ☐ Entire Right Arm ☐ Upper Right ☐ Lower Right

How often do you experience your symptoms?

☐ Constantly (76-100% of the time) ☐ Frequently (51-75% of the time)
☐ Occasionally (26-50% of the time) ☐ Intermittently (1-25% of the time)

How would you describe the pain?

☐ Sharp ☐ Numb ☐ Stiff ☐ Sharp with motion ☐ Shooting with motion
☐ Dull ☐ Tingly ☐ Stabbing with motion ☐ Electric-like with motion
☐ Diffuse ☐ Achy ☐ Burning ☐ Shooting ☐ Other _____

How are your symptoms changing with time?

☐ Getting Worse ☐ Staying the same ☐ Getting better

Using a scale from 0-10 (10 being the worst) how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 *(Please circle)*

How much has the problem interfered with your work activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How much has the problem interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Who else have you seen for your problems?

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER Physician
☐ Orthopedist ☐ Massage Therapist ☐ Physical Therapist ☐ No one
☐ Other _____

How long have you had this problem?_____ **Do you know the date it began?** _____

How do you think your problem began?

_____

Do you consider this problem to be severe?

☐ Yes ☐ Yes, at times ☐ No

What aggravates your problem?

_____

What alleviates the problem?

_____

What concerns you the most about your problem; what does it prevent you from doing?

_____

MID BACK:

(Initial here (_____) if this section DOES NOT apply, go to the next section)

Where is the pain?

☐ Left side ☐ Center ☐ Right side ☐ Entire mid back

How often do you experience your symptoms?

☐ Constantly (76-100% of the time) ☐ Frequently (51-75% of the time)
☐ Occasionally (26-50% of the time) ☐ Intermittently (1-25% of the time)

How would you describe the pain?

☐ Sharp ☐ Numb ☐ Stiff ☐ Sharp with motion ☐ Shooting with motion
☐ Dull ☐ Tingly ☐ Stabbing with motion ☐ Electric-like with motion
☐ Diffuse ☐ Achy ☐ Burning ☐ Shooting ☐ Other _____

How are your symptoms changing with time?

☐ Getting Worse ☐ Staying the same ☐ Getting better

Using a scale from 0-10 (10 being the worst) how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 *(Please circle)*

How much has the problem interfered with your work activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How much has the problem interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Who else have you seen for your problems?

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER Physician
☐ Orthopedist ☐ Massage Therapist ☐ Physical Therapist ☐ No one
☐ Other _____

How long have you had this problem?_____ **Do you know the date it began?** _____

How do you think your problem began?

_____

Do you consider this problem to be severe?

☐ Yes ☐ Yes, at times ☐ No

What aggravates your problem?

_____

What alleviates the problem?

_____

What concerns you the most about your problem; what does it prevent you from doing?

_____

LOW BACK/HIP:

(Initial here (_____) if this section DOES NOT apply, go to the next section)

Where is the pain?

☐ Left side ☐ Center ☐ Right side ☐ Entire low back

How often do you experience your symptoms?

☐ Constantly (76-100% of the time) ☐ Frequently (51-75% of the time)
☐ Occasionally (26-50% of the time) ☐ Intermittently (1-25% of the time)

How would you describe the pain?

☐ Sharp ☐ Numb ☐ Stiff ☐ Sharp with motion ☐ Shooting with motion
☐ Dull ☐ Tingly ☐ Stabbing with motion ☐ Electric-like with motion
☐ Diffuse ☐ Achy ☐ Burning ☐ Shooting ☐ Other _____

How are your symptoms changing with time?

☐ Getting Worse ☐ Staying the same ☐ Getting better

Using a scale from 0-10 (10 being the worst) how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 *(Please circle)*

How much has the problem interfered with your work activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How much has the problem interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Who else have you seen for your problems?

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER Physician
☐ Orthopedist ☐ Massage Therapist ☐ Physical Therapist ☐ No one
☐ Other _____

How long have you had this problem?_____ **Do you know the date it began?** _____

How do you think your problem began?

_____

Do you consider this problem to be severe?

☐ Yes ☐ Yes, at times ☐ No

What aggravates your problem?

_____

What alleviates the problem?

_____

What concerns you the most about your problem; what does it prevent you from doing?

_____

LEG:

(Initial here (_____) if this section DOES NOT apply, go to the next section)

Where is the pain?

☐ Entire Left Leg ☐ Upper Left ☐ Lower Left ☐ Entire Right Leg ☐ Upper Right ☐ Lower Right

How often do you experience your symptoms?

☐ Constantly (76-100% of the time) ☐ Frequently (51-75% of the time)
☐ Occasionally (26-50% of the time) ☐ Intermittently (1-25% of the time)

How would you describe the pain?

☐ Sharp ☐ Numb ☐ Stiff ☐ Sharp with motion ☐ Shooting with motion
☐ Dull ☐ Tingly ☐ Stabbing with motion ☐ Electric-like with motion
☐ Diffuse ☐ Achy ☐ Burning ☐ Shooting ☐ Other _____

How are your symptoms changing with time?

☐ Getting Worse ☐ Staying the same ☐ Getting better

Using a scale from 0-10 (10 being the worst) how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 *(Please circle)*

How much has the problem interfered with your work activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How much has the problem interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Who else have you seen for your problems?

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER Physician
☐ Orthopedist ☐ Massage Therapist ☐ Physical Therapist ☐ No one
☐ Other _____

How long have you had this problem?_____ **Do you know the date it began?** _____

How do you think your problem began?

_____

Do you consider this problem to be severe?

☐ Yes ☐ Yes, at times ☐ No

What aggravates your problem?

_____

What alleviates the problem?

_____

What concerns you the most about your problem; what does it prevent you from doing?

_____

I AFFIRM I HAVE ANSWERED ALL SECTIONS REGARDING MY HEALTH TO THE BEST OF MY ABILITY.

Patient Signature _____ Date:_____

Guardian or Spouse's Signature _____ Date _____

Shipley Chiropractic
Larry A. Shipley, DC
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(520) 797-2922 FAX (520) 742-0732

PERSONAL INJURY QUESTIONNAIRE

SLIP/FALL/LIABILITY/WORKER'S COMPENSATION

Name _____ Date of Accident_____Time _____ AM PM

Address _____ City/State/Zip_____

Where did accident happen? _____

Was it work related? Yes No If yes, did you report the accident to your Supervisor? Yes No

What is our Supervisor/Manager's name _____ Employer Phone _____

What is the name of your employer? _____

Employer Address _____ City/State/Zip_____

Describe the accident in your own words:_____

_____

_____

_____

_____

What caused your accident? _____

What were the conditions that caused your accident? (objects, weather, ice, etc.) _____

Immediately following the accident, how did you feel? _____

_____

Were you unconscious? Yes No In a daze? Yes No

Did you go to a hospital? Yes No If yes, when? _____

How did you get to the hospital? ____Ambulance ____Private transportation; Driven by _____

Name of hospital _____Attended by Dr._____

Were you x-rayed at the hospital? Yes No Diagnosis: _____

Were you admitted to the hospital? Yes No If yes, how long?_____

What treatment was rendered? _____

Did your employer send you to a doctor? Yes No If yes, Doctor's name _____

Did you go to a doctor on your own? Yes No If yes, Doctor's name _____

Have you lost any time from work as a result of this accident? Yes No If yes, give dates _____

Are there any other problems that effect your employment? **(Not accident related)** _____

Does your job cause you to favor one side of your body? _____

Have you injured this/these area(s) before? Yes No If yes, please explain _____

Who is responsible for payment? _____

Address _____ Phone _____

Policy/Claim Number _____

Have you retained an Attorney? Yes No If yes, Attorney's Name_____

Attorney's Address _____ Phone _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____
Patient Name (please print)

_____ _____
Signature Date

_____ _____
Parent, Guardian or Patient's legal representative Date

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC
INFORMED CONSENT

Shipley Chiropractic - 2292 West Magee Road, Suite170 - Tucson, AZ 85742
(520) 797-2922 Fax (520) 742-0732

CHIROPRACTIC
It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions.
It is important to understand what to expect from chiropractic health care services.

ANALYSIS
A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VCS). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS
Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE
A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice an is available to work with other types of providers in your health care regime.

RESULTS
The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic care. Many medical failures find quick relief through chiropractic. In turn w must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT
Please discuss any questions or problems with the doctor **before** signing this statement of policy.

I have read, and understand the foregoing.

_____ _____

Signature Date

OFFICE POLICY

Shipley Chiropractic - 2292 West Magee Road, Suite170 - Tucson, AZ 85742
(520) 797-2922 Fax (520) 742-0732

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. *Please read each section carefully and initial.* If you have any questions, do not hesitate to ask a member of our staff.

Appointments

1) We value the time we have set aside to see you. We do not double book appointments. If you are not able to keep an appointment, we would appreciate 24-hour notice.
2) Walk-ins welcome, however, appointments will be seen first.
3) If you are not able to keep a **massage** appointment, we require a 24-hour notice. If you do miss an appointment or do not cancel a massage appointment 24 hours prior to your scheduled appointment time, a cancellation fee will apply. For a half hour massage- $30 will be charged, for a1 hour massage- $58 will be charged, and for an hour and a half massage- $85 will be charged.
4) If you are late for your appointment (>15 minutes), we will do our best to accommodate you.
5) We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
6) If you have not been in the office in 3+ months, or if you have a new or different injury, a re-exam will be carried out and charged to you or your insurance company.

Initial_____

Insurance Plans

1) It is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.**
2) It is your responsibility to know if a written referral or authorization is required to see specialists. If a referral is required, it is up to you to get a referral from your primary care physician. If a referral is required and not received, your insurance company will not pay; you will be responsible for payment.
3) It is your responsibility to understand your benefit plan with regard to chiropractic and physical therapies.
4) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
5) **Co-payments** are due at the time of service.
6) Self-pay patients are expected to pay for services in FULL at the time of the visit.
7) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within **10** business days of your receipt of your bill.
8) We accept cash, checks, Visa, and MasterCard credit and debit.
9) A $25 fee will be charged for any checks returned for insufficient funds.

Initial_____

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

_____
Patient's Name

_____ _____
Signature Date

FINANCIAL AGREEMENT
WORKER'S COMPENSATION INJURY

Shipley Chiropractic - 2292 West Magee Road, Suite170 - Tucson, AZ 85742
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We would like to take a moment to welcome you to our clinic and to assure you that you will be receiving the very best care available for your condition. To familiarize you with the financial policies or our clinic, I would like to explain how your medical bills will be handled.

Party Responsibility
If you were involved in an auto accident and are the owner of the vehicle, we will bill the medical insurance portion of your own automobile insurance policy. If you were ***a passenger in someone else's car***, we will bill the ***driver's*** auto insurance company. These policies will be billed in addition, and prior to, any claim that your attorney may be presenting to an insurance company on your behalf.

Insurance Rates
It is important to remember that when a medical claim is submitted to the "medical payments" portion of your insurance policy, your standing with the insurance company will not be affected, and your rates will not normally be increased, unless the accident is determined to be your fault.

Billing Other Insurance Policies
It is also to your advantage for our clinic to bill your own health insurance policy and/or automobile medical policy for your medical bills, providing your policy does not state otherwise. Any money received above and beyond your total bill in this clinic will be refunded to you.

Responsibility for Payment
As a courtesy to you, we will gladly submit your medical bills to your insurance company(ies) and/or attorney; however, all services rendered by this clinic will be charged directly to you, and ultimately, you will be personally responsible for payment of these bills regardless of any settlement you may or may not receive.

Once again, we welcome you to this clinic. We hope that this has answered any questions that you might have about our financial arrangements. If, at any time, you have further questions about your care, please don't hesitate to ask.

I have read and agree to the above

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Patient's Signature Date