Virginia Sports and Spine

4041 University Drive #100, Fairfax, VA 22030

571-344-3744

Name: ____ Date of Birth: ____________________________

Address: ____

Cell Phone: ____________________________________ Home Phone: _____________________________

Email: ____

Emergency Contact Name: _________________________ Contact Number: ___________________________

Marital Status: Single Married Divorced Gender: Male Female

Insurance Information

Insurance Name: ____________________________ ID #:______________________Group #:___________

Assignment of Benefits Authorization

I authorize I have coverage with above insurance company. I hereby assign all my or my dependent's insurance benefits to Virginia Sports & Spine to charge for the services provided. I understand that I am financially responsible if my insurance company does not pay for the services provided to me. By signing this document, I authorize Virginia Sports & Spine to have access to my insurance benefits, submit claims, and other related services. I understand Dry Needling is an additional $25 per visit if received. I have read and understand the above statement.

Notice of Privacy Practices

It is the law that all medical records and other health information used or disclosed by us in any form (electronically, paper, or orally) are kept confidential and will not be released unless requested by the patient. The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program protecting patient's identity. HIPPA gives patients the rights to have access to their health records. Breach of this privacy by provider is penalty by law. Your records may be used for the purposes of treatments, payments, and health care operations at our office. I understand that, under HIPPA, I have the certain rights to privacy regarding my protected health records. I understand this information can and will be used for treatment, payments, and other health office operations at Virginia Sports & Spine.

Cancellation/No Show Policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 48 hours notice for any cancellations or changes to your appointment. Patients who provide less than 48 hours notice, or miss their appointment, will be charged a $50 cancellation fee.

Consent to Treat

I have been informed of the nature of my condition(s) and the nature of Chiropractic services to provide treatment. I have also been informed of the possible risks of the treatment(s) and understand that there is no guarantee for any specific cure or result. I have read and understand the above statement. I hereby authorize Virginia Sports and Spine to proceed with Chiropractic treatments.

Name: ______________________________ Signature: ____________________________ Date:_____________

Chief Complaint

Reason for today's visit? _____________________________________

You pain scale: 0(no pain) 1 2 3 4 5 6 7 8 9 10 (extreme pain)

When it started? ____

How it started? ____

How long has it been? ____

What aggravates it? ____

What alleviates it?____

What treatments are you receiving/received so far? ____

Current medication list: ____

Do you smoke? _____________________________ Do you drink? ______________________________________

Diet: _______________________________________ Exercise: ____

Work activity: ____

Past Medical History

Last Physical results: ____Date: ___________

X-ray/MRI/Labs results: ____ Date: ___________

Injuries: ____ Date: ___________

Surgeries: ____Date: ___________

Hospitalizations: ____ Date: ___________

Immunizations: ____ Date: ___________

Allergies: ____ Date: ___________

Additional information: ____ Date: ___________

Family Medical History

Father's medical conditions: ____

Mother's medical conditions: ____