



AUTHORIZATION FOR CHIROPRACTIC TREATMENT

I, the undersigned, a patient in this office, hereby authorize Virginia Family Chiropractic to administer such treatments as is necessary, and to perform the following therapy and manipulation and such additional therapy or procedures as are considered therapeutically necessary on the basis of finding during the course of said treatment.

I hereby certify that I have read and dully understand the above Authorization for Chiropractic treatment, the reason why the above named treatment is considered necessary, the benefits and risks the side effects of the treatment, which were explained to me by Virginia Family Chiropractic.

I understand and am informed that, as in all health care, in the practice of chiropractic there are some risks to treatment, including but not limited, to muscle strains and sprains, fractures, dislocations, disc injuries, strokes. I do not expect the doctor to be able to anticipate or explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatments which he feels at the time, based upon the facts then known is my best interest.

My doctor has responded to all of my requests for information about proposed treatment. I have read, or have had read to me, the above consent. I have also had the opportunity to ask about its content. By signing below, I consent to treatment. I also certify that no guarantee of assurance has been made as to the results that may be obtained.

Print Name

Date

Signature

Witness or Nearest Relative



Health Care Authorization Form (HIPAA)

ALEXANDRIA

5130 Duke St Suite 114
Alexandria, VA 22304
P: (703) 370-5300
F: (703) 370-0080

WOODBIDGE

14904 Jefferson Davis Hwy. Suite 301
Woodbridge, VA 22191
P: (703) 499-8840
F: (703) 499-8842

FALLS CHURCH

7121 Leesburg Pike, Suite 207
Falls Church, VA 22043
P: (703) 538-3830
F: (703) 538-3831

MANASSAS

8420 Dorsey Circle Suite 101
Manassas, VA 20110
P: (703) 367-7878
F: (703) 367-0009

THE FOLLOWING AUTHORIZES VIRGINIA FAMILY CHIROPRACTIC & PM PLLC TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATION:

I give permission to Virginia Family Chiropractic PM PLLC to use my name, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related email messages, text messages, and information about treatment alternatives or other health related information.

I give permission to Virginia Family Chiropractic PM PLLC to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a doctor or assistant in private, the doctor or assistant will provide a private room for these conversations BY APPOINTMENT ONLY.

By signing the following, you are giving Virginia Family Chiropractic PM PLLC permission to use and disclose your protected health information in accordance with the directives listed above.

Signature of Patient/or Guardian

Date

Printed Name of Patient/or Guardian

ACKNOWLEDGEMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures: I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health care information for directory purpose.
- The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations.

Signature of Patient/or Guardian

Date

Printed Name of Patient/or Guardian



Medical Information Release Form (HIPAA)

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Name

Date of Birth

I authorize the release of information including the diagnosis, records, and examination rendered to me claims information. This information may be released to:

Spouse _____

Child(ren) _____

Other _____

Information is NOT to be released to anyone

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call my home my work my cell number _____

If unable to reach me:

You may leave a detailed message

Please leave a message asking me to return your call

The best time to reach me is (day) _____ between (time)

Signature of Patient/or Guardian

Date

Witness

Date



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Patient Registration and History Questionnaire

Name: _____ Age: ____ Date of Birth: _____ Date: _____
Last First MI

Address: _____ Social Security #: _____ - _____ - _____

City, State, Zip: _____ Marital Status: M S W D

Home Phone: (____) _____ Work/Cell Phone: (____) _____

Email: _____ @ _____ .com Employer: _____

Occupation: _____ How were you referred to this office? _____

In case of an emergency, notify _____ Relationship: _____

Phone: (____) _____

Reason for Office Visit:	Date condition started:	Have you had this before?	Injury related?
1. _____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
2. _____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
3. _____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no

Pain severity: If 10 is the worst pain imaginable, and 0 is no pain, please indicate your pain over the last 2 weeks:

Pain location:	Pain location:	Pain Location:
RIGHT NOW: ____/10	RIGHT NOW: ____/10	RIGHT NOW: ____/10
At its WORST: ____/10	At its WORST: ____/10	At its WORST: ____/10
At its BEST: ____/10	At its BEST: ____/10	At its BEST: ____/10

What makes your pain BETTER? (Check all that apply):

- Nothing Ice Heat Massage/Rubbing Exercise/Activity Sitting
- Standing Rest Stretching "Popping" the joints Bracing/taping Laying

What makes your pain WORSE? (Check all that apply):

- Coughing Sneezing Bearing Down Sexual Intercourse Running Standing
- Lifting Bending Pushing Pulling Driving Sitting
- Walking Laying Down Movement of the head Movement of the low back
- Other _____

Pain Quality: How would you describe your pain/discomfort (check all that apply)

- Dull Achy Stiff Intense Throbbing Sharp Sharp with movement
- Stabbing Shooting Burning Constricting Annoying Tight Unbearable



VIRGINIA FAMILY
Chiropractic & Physical Medicine

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Numbness/Tingling (pins and needles): Yes, No: Please describe where and when you feel these symptoms: _____

Are symptoms: -Constant >75%- -Frequent 51-75%- -Occasional 26-50%- -Intermittent <25% of your waking hours

Have you seen a Chiropractor before? yes no Who? _____

When? _____ Reason for visits? _____

How did you respond? _____

Medical Doctors:

Name: _____ Date of last visit: _____ Is this your primary care provider? yes no

Name: _____ Date of last visit: _____ Is this your primary care provider? yes no

Name: _____ Date of last visit: _____ Is this your primary care provider? yes no

Surgeries/Hospitalization and dates: _____

Medication: OTC/Prescription/Supplements/Vitamins: _____

Please list all serious illness and serious accidents: _____ **Month and Year:** _____ **City, State:** _____

List any allergies to medications, food or other: _____

Are you pregnant? ... Yes ... No First day of last menstrual cycle: _____

Do you smoke? ... Yes ... No; How much? _____ Do you drink alcohol? ... Yes ... No; How much? _____

Please list any recent x-rays, lab or other tests: _____ **Month and Year:** _____ **Facility/Doctor:** _____

Do you have a history of any of the following diseases?

Tuberculosis ... Yes	Lung Disease ... Yes	Gout ... Yes	Diabetes ... Yes
Kidney Disease ... Yes	Stomach/Ulcer ... Yes	Heart Attack ... Yes	Hepatitis ... Yes
Sciatica ... Yes	Blood Pressure ... Yes	Transfusion ... Yes	Polio / MS... Yes
Colon Disease ... Yes	Stroke ... Yes	Cancer ... Yes	Bleeding ... Yes
Paralysis ... Yes	Seizures ... Yes	Arthritis ... Yes	Asthma ... Yes
Anemia ... Yes	Thyroid Disease ... Yes	Drug Dependence ... Yes	AIDS ... Yes

Any other condition(s) not listed above that the doctor should be made aware of: _____



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Postural distortions from subluxations in your neck, upper back, middle back and low back will negatively influence and affect the nerves throughout the entire body. Do you NOW or have you EVER experienced:

CERVICAL SPINE (NECK):

- Neck pain Headaches Pain into shoulders/arms/hands Immune system weakness
- TMJ/pain/clicking Dizziness/fainting Weakness in grip Arthritis in the neck
- Allergies/ hay fever Allergies Visual disturbances Hearing disturbances
- Coldness in hands Low energy/fatigue Recurrent colds/flu Thyroid conditions
- Sinusitis Depression Numbness/tingling in arms/hands Anxiety

THORACIC SPINE (UPPER BACK):

- Upper back pain Shoulder pain Heart attacks/angina Pain on deep inspiration/expiration
- Heart palpitations Tachycardia Shortness of breath High blood pressure
- Heart murmurs Asthma/wheezing High Cholesterol Recurrent lung infections/bronchitis

THORACIC SPINE (MID BACK):

- Mid back pain Pain into ribs/chest Scoliosis Kidney disease Diabetes
- Ulcers/gastritis Indigestion/Heartburn Hypoglycemia Gall bladder problems Nausea
- Acid reflux Tired/irritable after eating or when you haven't eaten for awhile

LUMBAR SPINE (LOW BACK):

- Low back pain Pain into hips/legs/feet Weakness/injuries in hips/knees/ankles
- Numbness/tingling in legs/feet Muscle cramps in legs/feet Coldness in legs/feet
- Recurrent bladder/urinary tract infections Muscle cramps in legs/feet Constipation
- Menstrual irregularities/ cramping Diarrhea Sexual dysfunction Scoliosis

FAMILY HEALTH HISTORY:

Have any of your biological family members ever been diagnosed with the following:

- Mental Health Disease Neurological Problems Lung Disease Thyroid Arthritis
- Circulatory Problems Heart Murmur Cancer High Blood Pressure Heart Disease
- Stroke Diabetes Scoliosis Kidney Disease Migraine Headaches

RADIOGRAPHY CONSENT:

In order to best determine the cause and extent of my underlying spinal problems, I hereby give my consent to allow Virginia Family Chiropractic PM, PLLC to take spine and other relevant radiographs as deemed clinically necessary through chiropractic history/examination and in accordance with clinical usage indications as published in the Practicing Chiropractors Committee on Radiology Protocols for Biomechanical Assessment of Spinal Subluxation in Chiropractic Clinical Practice (2009).

Signature of Patient/or Guardian

Dat

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We provide you with the same information your insurance gives our billing coordinator. If you have any additional questions regarding your benefits or coverage, please contact your insurance carrier directly.

Co-payments are to be made at **EACH** visit. If you have a **co-insurance**, you will pay a portion at the time of each visit. For example if your portion is 10%, you would pay \$10 each visit; 20%, you would pay \$20 and so on. You may owe an additional amount which we will collect once your claim has been processed.

Patients that have **deductibles** will be responsible for the contracted rate of your treatment per visit until the deductible has been met. This payment will be applied to your deductible once we receive an explanation of benefits from your insurance carrier. You may owe an additional amount which we will collect once all insurance payments have been applied, or have a credit depending on the claim processing.

Referrals: Insurance companies (HMO's) sometimes require their members to obtain a referral from their primary care doctor before seeing a specialist such as a chiropractor. **It is your responsibility** to obtain a referral if needed, and you must do so prior to your scheduled appointment or you will be forced to reschedule. If a referral is not received, you are financially responsible for any charges incurred for that date of service. Be aware that most referral authorizations are good for a certain number of visits and have an expiration date. If you have any questions about obtaining a referral we will be happy to assist you.

The contracted rate is an estimate we have of what your insurance allows. If you have an outstanding balance we will send you (3) statements. If we do not receive payment by the third which is the final statement, further collection action will take place immediately. Should you have any questions regarding the statement, PLEASE CALL US IMMEDIATELY in order to speak with the billing coordinator.

Returned Checks: You will be charged a \$40 returned check fee if a personal check is returned for nonpayment.

A fee of \$25.00 is charged if you do not cancel at least 24 hours prior to your scheduled appointment time or **"no-show."**

PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE.

DATE

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE.

Patient History Review of Systems

VIRGINIA FAMILY
Chiropractic & Physical Medicine

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0 = NEVER HAD 1 = PATIENT PRESENTLY HAS 2 = PREVIOUSLY HAD

GENERAL		MUSCULOSKELETAL		NEUROLOGICAL	
Recent weight gain		Arthritis		Lightheaded/dizzy	
Recent weight loss		Rheumatoid arthritis		Memory loss	
Fatigue		Broken bones		Headaches	
Fever		Osteoporosis		Migraines	
Allergies		Gout		Numbness	
Loss of appetite		Scoliosis		Weakness	
Chills		Spinal trauma		Stroke	
Cancer of any kind		Joint pain (anywhere)		Tingling/Numbness	
CARDIOVASCULAR		RESPIRATORY		INTEGUMENTARY (SKIN)	
Heart attack		Coughing		Bruise easily	
Swelling of ankles		Coughing up blood		Skin rashes	
High blood pressure		Chronic cough		Discoloration	
Low blood pressure		Chest pain		Psoriasis	
Shortness of breath		Asthma		Changes in moles	
Pain down left arm		Pneumonia		Sores	
Profuse sweating		Bronchitis		Scars	
High cholesterol		Tuberculosis		Itching	
EYES, EARS NOSE & THROAT		GASTROINTESTINAL		GENITOURINARY	
Blurred vision		Gall bladder problems		Painful urination	
Double vision		Liver problems		Blood in urine	
Ear pain		Pain over stomach		Frequent urination	
Hoarseness		Ulcers		Kidney infection	
Nose bleeds		Colitis		Kidney stones	
Glaucoma		Hiatal hernia		Incontinence	
Dental problems		Blood in stool			

OTHER/EXPLANATIONS:

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE.



NEW OFFICE POLICY

ALEXANDRIA

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Time is a very limited commodity; once it is lost, it cannot be regained. Like most physician's offices, we are a time-dependent business that runs on appointments. This assures that every patient receives adequate treatment and attention.

If you don't show up/or cancel on time: At Virginia Family Chiropractic, we put our faith in you to keep your appointment and be on time. We know you put your faith in us to see you on time as well as take good care of you. When we schedule an appointment, a specific amount of time is reserved especially for you! Because appointments are in high demand, if for any reason you must cancel or change your appointment, it is important that you give our office at least 24 hours' notice to offer that spot to someone else. Without a 24 hour notice of cancellation, you will be charged a \$25 "no show fee."
We understand emergencies and life happen! If you provide adequate documentation of your emergency/illness, then the \$25 charge will be removed from your account.

If you're late:

If you are late, it is your therapy that is affected. When we reserve time for you, we require all of that time to provide you with the best quality care possible. When you are late it decreases our ability to accomplish this. If you arrive more than 15 minutes late for your appointment time, you may be rescheduled in order to meet the needs of those who are on time. Priority will be given to the patients who arrive on time. One or two late patients can cause the entire daily schedule to fall behind. This is an inconvenience to everyone. We strive to see every patient as close to their appointment time as possible. If you arrive late, the physician may need to reschedule. We will try to accommodate late-comers as best as possible, but cannot compromise on the quality and timely care provided to our other patients.

Walk-In Patient Policy

Patients are encouraged to make appointments. Having an appointment enables us to have your medical chart available at the time of your visit, allows the clinician to review the information prior to your visit and gives the staff an opportunity to properly schedule your visit.
Walk-in patients will be seen determinant on the office flow per day. Patients with appointments will have priority to be seen, and you may experience longer wait times without an appointment.
Further, if you walk-in without an appointment, you must arrive at least 45 minutes from the time that we close, or you will be asked to schedule an appointment for a future date.
If you are experiencing a medical emergency, we ask that you call the office in advance, or call 911.

I have read and understand the above statement.

_____ Patient Initials