

NEW PATIENT INFORMATION

REFERRED BY _____

NAME _____ Age: _____ Birthdate _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE # _____ CELL# _____ SS # _____

E-MAIL _____ RELATIVE'S PHONE #: _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ WORK PHONE _____

CITY _____ STATE _____ ZIP _____

PRIMARY INSURANCE _____

INSURED'S NAME _____ INSURED'S BIRTHDATE _____

INSURED'S ID # _____ RELATIONSHIP _____

GROUP # _____ INSURED'S EMPLOYER _____

INFORMED CONSENT FOR CARE: I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Wasserman. I will have the opportunity to discuss with Dr. Wasserman and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him, is in my best interest. I have read, or have had read to me, the above consent. I will have an opportunity to ask questions about its content, **and by signing below I agree to the above-named procedures.** I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) or which I seek treatment here at this office.

I ALSO GIVE MY FULL AND COMPLETE PERMISSION FOR THIS MEDICAL GROUP TO TREAT MYSELF OR MY MINOR CHILD. I ACCEPT FULL FINANCIAL RESPONSIBILITY, AND **ASSIGN ALL MY PAYMENTS DUE TO THE DOCTOR.** I HEREBY AUTHORIZE THE GROUP TO RELEASE TO MY INSURANCE CARRIER ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT REQUIRED FOR THE PURPOSE OF BILLING. A PHOTOCOPY OF THIS ASSIGNMENT WILL BE AS VALID AS THE ORIGINAL.

THIS COMPLAINT OF _____ WAS **NOT** CAUSED BY AN AUTOMOBILE ACCIDENT, RELATED TO EMPLOYMENT, OR OCCUR ON COMMERCIAL PROPERTY.

SIGNATURE _____ DATE _____

Initial Symptom History

Please state your **primary complaint** of why you are here today: _____

What caused this and how long have you had it: _____

Have you had this condition in the past? _____

Please put a **check** that applies to your present condition:

Frequency: ____rare ____occasional ____frequent ____constant

Symptoms: ____pain ____stiffness ____spasms

Intensity: 0 (none)- 10 (severe) = ____neck ____mid ____low back ____extremity

Quality: ____sharp ____dull ____stabbing

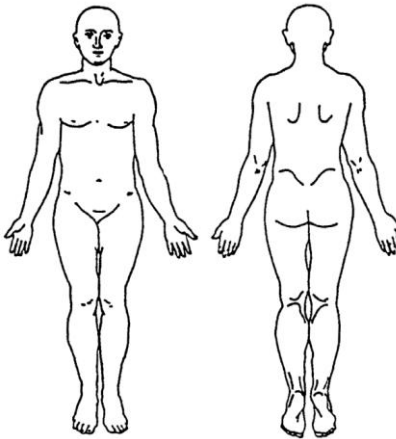
Assoc. Symptoms: ____weakness ____limited ranges of motion

radiating pain into _____ numb/tingling of _____

Aggravated by prolonged: ____sitting ____standing ____walking ____lying down ____driving

Relieved by: ____rest ____movement ____stretching ____Rx ____ice ____heat

Please mark the areas where your current complaints are located:



Signature _____ Date _____

INITIAL HEALTH HISTORY

Allergies:_____

Medications/Supplements_____

Cholesterol Lowering Drugs:_____

Surgeries/Hospitalizations:_____

Pace Maker/Metal /Breast Implants_____

Cancer:_____

Diabetes:_____

Heart Disease:_____

Stomach/Colon:_____

Etc._____

Spinal Injuries/Accidents:_____

Previous Chiropractic Care: _____

Last Menstrual Period:_____ PREGNANT? () YES () NO

Previous MRI, CT Scans; X-Rays:_____

Exercise/Sports Activities:_____times per week: 1 2 3 4 5 6 7

Average Daily Emotional Stress Level: ()very high ()high ()medium ()minimal

Patient Signature_____ **Date**_____

Comments:

STEVEN B. WASSERMAN, R.N., D.C.
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Out-of-Network, and Non-Participating, and Out of State Policies; Provider Acknowledgement: Blue Cross, United Health Care, CIGNA, Etc..

Patient's Name:_____ **Date:**_____

I _____, understand that Dr. Wasserman is no longer a participating provider with my insurance company. Therefore, I will be responsible for all services rendered at time of service.

Dr. Wasserman's office may as a courtesy bill my insurance company (if applicable). I am aware that I may or may not receive a reimbursement check in the mail from my insurance company, depending on my insurance company's contract and benefits, for services provided by Dr. Wasserman.

I understand that payment will be due at the time of services rendered.

I understand this is not a guarantee that my insurance will cover the services received by me and that all services may be subject to review by my insurance company. (Please consult your insurance company to verify eligibility and benefits.)

I fully understand and agree with the above terms above.

Patient's Signature

Date

FEES

Initial consultation, exam, adjustment, with or without PT: \$175.00

Initial consultation, exam: \$125.00

Adjustment and PT: \$65.00

Adjustment with or without hot pack: \$45.00

Patient not seen > 90 days; consultation, re-exam, adjustment, with or without PT: \$75.00

X-rays: \$75.00-\$150.00

Supplies: separate charge per item (PT=electrical stimulation, manual traction, laser, and /or ultrasound)