HarmonizedNeurology
FAMILY CHIROPRACTIC

105 Bulifants Blvd, Suite B
Williamsburg, VA 23188
757-707-3020
care@harmonizedneurology.com
www.harmonizedneurology.com

Adult Patient Questionnaire

1. CONFIDENTIAL PATIENT INFORMATION:

Name _____ Date of Birth _____ Gender _____

Preferred Name _____ Email _____

Street Address _____ Apt/Unit # _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Work Phone _____

Occupation

_____

Emergency Contact/Cell Phone/Relationship:

_____

Who is your primary care physician?

_____

2. How did you hear about us? Please select all that apply.

- ☐ Current Patient (list who)_____
- ☐ Professional Referral/Doctor (list who) _____
- ☐ PX Docs website_____
- ☐ Community Partner (list who) _____
- ☐ Google Search (what terms did you search?) _____
- ☐ Facebook ☐ Other (please specify)_____

3. Please list any other health professionals you are seeing and their area of expertise.

_____
_____
_____
_____
_____
_____

4. Please list any drugs/medications/herbs/vitamins/other that you are currently taking.

Medication/Supplement	Dosage	Frequency	Reason for Taking

Others: _____

CURRENT HEALTH CONDITIONS

5. What are your primary health concerns?

_____
_____
_____
_____

6. Please describe when these issues first began and how they've progressed since:

_____
_____
_____
_____

7. What makes things better?

_____
_____
_____

8. What makes things worse?

_____
_____
_____

HEALTH GOALS

9. What are your top 3 health goals?

1. _____
   _____
2. _____
   _____
3. _____
   _____

10. What would you like to gain from chiropractic care?

☐ Resolve existing condition ☐ Overall wellness & prevention ☐ Both

11. If you've ever visited a chiropractor before, please list their name(s) and specialty:

_____

_____

12. Please list any food intolerances or allergies and when they began:

Food intolerance / Allergy	When it began

13. Please list any hospitalizations or surgeries and the year:

Hospitalization / Surgery	Year

14. Please list any major injuries, accidents, falls, concussions, and/or fractures you have sustained in your lifetime and the year:

Injury	Year

15. If you're having difficulty sleeping, please explain: _____

_____

_____

_____

16. How many hours per night do you usually sleep? _____

17. How many hours per day do you typically spend working at a desk or sitting? _____

18. How would you describe your diet?_____

_____

_____

_____

19. Are there any other health concerns or is there anything else you'd like for us to know? _____

_____

_____

_____

_____

_____

_____

_____

PATIENT REVIEW OF SYSTEMS

The nervous system controls and coordinates all organs and structures of the human body. Please check the corresponding boxes for each symptom or condition you have experienced – past and/or present.

	Past	Present
ADHD/ADD		
Allergies and/or Autoimmune Challenges		
Anxiety		
Asthma		
Autism		
Balance and Coordination Challenges		
Behavior Issues		
Bladder and Urination Issues		
Blood Sugar Issues		
Bronchitis and Pneumonia		
Chronic Chest Colds and Cough		
Chronic Inflammation		
Circulation Issues and Cold Feet		
Constipation		
Depression		
Ear and/or Sinus infections		
Gas Pain and Bloating		
Gluten and/or Casein Intolerance		
Handwriting and Fine Motor Skill Challenges		
Headaches or Migraines		
Hormonal Challenges		
Hyperactivity and Impulsivity		
Jaw, Swallowing, Sensory Food Aversions		
Kidney Challenges		
Lightheadedness and Dizziness		
Low Back Pain and Stiffness		
Low Energy/Fatigue		
Lumbopelvic/SI Joint Pain		
Metabolism and Weight Control Issues		
Nausea and Malaise		
Projectile Vomiting		
Reflux/GERD		
Sensory Processing Challenges		
Skin Conditions / Rashes		
Sleeping Difficulties		
Social/Emotional Challenges		
Sore Throat / Strep / Upper Respiratory Infections		
Stiff Neck and Shoulders		
Tight Hamstrings and Calves		
Ulcerative Colitis / Crohn’s / IBS		
Vision and/or Hearing Issues		
Visual and/or Auditory Processing Challenges		
Weak Ankles and Arches		

ACKNOWLEDGEMENT AND CONSENT

Patient

_____ _____

Signature Date

Doctor

_____

Signature

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefits, may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include strain/sprain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate of 1 or 2 instances per one million cervical spine adjustments, may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care at Harmonized Neurology Family Chiropractic, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health, and your spine health. These procedures will assist us in determining if chiropractic care is needed or if any further examinations or studies are required. In addition, they will help us determine if there is any reason to modify your care or provide a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand that alternatives to chiropractic care may include physical therapy, medical care, or other interventions, and I am free to discuss these options before proceeding.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care, including spinal adjustments, as reported following my assessment.

I understand that I have the right to ask questions and withdraw my consent for care at any time.

For Minors or Dependents
If signing for a minor or dependent, I confirm that I am their legal guardian and authorized to consent to care on their behalf.

Acknowledgment of Understanding
I acknowledge that I have had the opportunity to ask questions about this consent form and that all my questions have been answered to my satisfaction.

Practice Information
Harmonized Neurology Family Chiropractic
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Signatures
Patient Name (Printed): _____
Patient Signature: _____
Date: _____

If signing for a minor or dependent:
Guardian Name (Printed): _____
Guardian Signature: _____
Date: _____

Witness Name (Printed): _____
Witness Signature: _____
Date: _____

Acknowledgment of Privacy Practices Notice Availability

This is to acknowledge that I have been informed of the availability of the Notice of Privacy Practices from Harmonized Neurology Family Chiropractic. I understand that:

1. I may request a full copy of the Notice of Privacy Practices at any time.
2. The Notice of Privacy Practices explains how my health information may be used and disclosed and outlines my rights regarding this information.
3. A summary of the Notice of Privacy Practices is also available for my convenience.

I further understand that I am entitled to ask any questions about the Notice of Privacy Practices or seek clarification if needed.

Patient Name (Printed): _____
Patient Signature: _____
Date: _____

If you have any questions or require a copy of the Notice of Privacy Practices, please let us know. We are here to assist you.

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Financial Policy Agreement

Welcome to Harmonized Neurology Family Chiropractic! We are committed to providing you with the highest quality neurologically-focused chiropractic care. To ensure clear communication and understanding regarding our financial policies, we ask that you carefully read and sign this agreement before beginning treatment.

Payment for Services:

- **Payment Due at Time of Service:** Payment for services is due at the time the services are rendered, unless prior arrangements have been made in writing with our office.
- **Accepted Forms of Payment:** We accept the following forms of payment. Please note the cash versus card price adjustment.
    - Cash
    - Check (made payable to Harmonized Neurology Family Chiropractic
    - Visa, Mastercard, American Express, Discover
    - HSA/FSA cards
- **Returned Checks:** Returned Checks: If a check is returned by your bank for any reason (e.g., insufficient funds, closed account), you will be responsible for the following:
    - The original amount of the check.
    - Any fees charged to Harmonized Neurology by our bank for the returned check.
    - We recognize that mistakes happen and therefore, do not charge processing fees.

Insurance:

- **Non-Participating Provider:** Harmonized Neurology Family Chiropractic is a non-participating provider with all insurance plans, including Medicare and Medicaid. This means that we do not bill insurance companies directly.
- **Patient Responsibility:** You are responsible for the full payment of all services rendered at the time of service.
- **Superbill/Receipt:** Upon request, we will provide you with a receipt (superbill) for you to submit to your insurance company for potential out-of-network reimbursement. We make no guarantees regarding reimbursement from your insurance company.

Care Plans:

- We offer highly competitive and largely discounted Care Plans. Care plans are offered for both Restoration Care and Wellness Care. A signed Care Plan Agreement is required.

Missed Appointments/Cancellations:

- **Life is busy and we completely understand that unexpected things can happen and simply encourage you to share any scheduling conflicts with us as soon as possible.**
- **We request a 24-hour cancellation notice.**

Fees for Reports and Records:

- A fee may be charged for providing copies of medical records, reports, or other documentation. Please inquire about our current fee schedule.

Changes to Financial Policy:

- We reserve the right to modify this financial policy at any time. You will be notified of any significant changes.

Agreement:

I have read, understand, and agree to the financial policies outlined in this document. I understand that I am financially responsible for all services rendered at Harmonized Neurology Family Chiropractic.

Patient Signature _____

Printed Patient Name_____

Date _____

CONSENT TO COMMUNICATE

Patient Name: _____

I authorize Harmonized Neurology Family Chiropractic to contact me using the following methods (please check all that apply):

- ☐ **Phone call**
- ☐ **Email**
- ☐ **Text Message**

I understand that:

1. These methods of communication may not be secure, and there is a risk of unauthorized access.
2. The purpose of this communication may include appointment reminders, follow-ups, or practice updates.

I consent to receive communications from Harmonized Neurology Family Chiropractic and understand that I can revoke this consent in writing at any time.

Signature: _____ **Date**: _____

ADULT PHOTO RELEASE FORM

I, the undersigned, hereby grant Harmonized Neurology Family Chiropractic permission to use my likeness in a photograph, video, or other digital media in any and all of its publications, including web-based publications, without payment or other consideration.

I understand and agree that all photos will become the property of Harmonized Neurology Family Chiropractic and will not be returned. I hereby irrevocably authorize Harmonized Neurology Family Chiropractic to edit, alter, copy, exhibit, publish, or distribute these photos for any lawful purpose. In addition, I waive any right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photos.

I hereby hold harmless, release, and forever discharge Harmonized Neurology Family Chiropractic from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

Printed Name: _____

Signature: _____

Date: _____

If you are 65 or over, please complete:

Notice to Medicare Beneficiaries
Harmonized Neurology Family Chiropractic

Patient Name: _____
Date of Birth: _____

1. Purpose of this Notice
This document is to confirm that **Harmonized Neurology Family Chiropractic** does not participate in the Medicare program and will not submit claims to Medicare for any services provided.

2. Important Information for Medicare Beneficiaries

- **Non-Covered Services**: Medicare only covers manual manipulation of the spine for the treatment of musculoskeletal pain. Our office does not treat symptoms such as pain and only clears interference from the nervous system. Therefore, services provided at this office are not considered Medicare-covered services.
- **No Medicare Billing**: This office will not bill Medicare or submit claims on your behalf for any services rendered.
- **Payment Responsibility**: You are personally responsible for payment of all services at the time they are rendered.
- **No Reimbursement**: Medicare will not reimburse you for services provided by this office.

3. Acknowledgment of Understanding
By signing below, I confirm that:

1. I understand this office does not provide Medicare-covered services and will not file claims with Medicare.
2. I agree to pay for services directly and understand that I will not be reimbursed by Medicare for these charges.
3. I understand that I may seek chiropractic care from providers who participate in Medicare.

4. Signature and Agreement

I have read and fully understand the information provided in this document. I agree to the terms outlined above.

Patient Signature: _____
Date: _____

Provider Signature: _____
Date: _____