



MODERN
CHIROPRACTIC
CENTER

Dr. Robert Stein

9841 Pines Boulevard
Pembroke Pines, FL 33024

New Patient Consultation Form

Today's Date ____/____/____

Patient's Name _____

Mailing Address _____ City _____ State ____ Zip _____

Birth Date ____/____/____ Age _____

Cell Phone Number (____) ____-____ Home Phone Number (____) ____-____

Insured Name & ID _____ DOB: ____/____/____
(If different from patient)

Email Address: _____

Occupation _____

Hobbies _____

Please describe the pain and its location _____

Explain what happened _____

When did the condition begin? _____

Did the condition arise from auto accident, sports, work, trauma or other related reasons? _____

Is the condition getting worse or better? _____

Did you go to the Hospital for this condition? _____ if yes, explain the treatment or diagnostic testing you received _____

Did you go to a physician or other Chiropractor for this condition? _____ if yes, please explain the outcome of the treatment or visit _____

Have you had this condition in the past? _____ if yes, please explain _____

What activities aggravate the condition? _____

What activities relieve the condition? _____

Did you use Ice or Heat to try to relieve this condition? _____

What medication have you taken for this condition? _____

What medication or supplements are you presently on? _____

Please circle if you have had any of these conditions or diseases:

Heart attack	Stroke	Congenital Heart Disease	Alcoholism
Diabetes	Cancer	High/Low Blood Pressure	Drug Abuse
HIV	Headaches	Lower Back Pain	Shoulder Pain
Lung Problems	Neck Pain	Difficulty Breathing	Dizziness
Hepatitis	Epilepsy	Stomach Problems	Asthma
Arthritis	Concussions	Knee Problems	

Other Conditions: _____

Do you smoke tobacco? _____

Women: Are you Pregnant? _____ If yes, how many weeks? _____

In case of an emergency, who should we contact? _____

Emergency contact's relationship _____ and phone number _____

Financial Policy & Good Faith Estimate

Our Policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with the Doctor. If the account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for Small claims court fee, collection agency fees, legal fees, the doctor's hourly rate for court appearance, and any other expenses that are incurred in collecting on your account. Patient is responsible for the knowledge of their own insurance benefits, and is ultimately responsible for any treatments not covered by your insurance.

I authorize the staff to perform necessary services needed during diagnosis and treatment. I also authorize the provider and or manage care organizations, to release any information required to process insurance claims

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Under the No Surprises Act, you have the right to receive a Good Faith Estimate (GFE) explaining how much your chiropractic care will cost. If you are an uninsured or self-pay patient seeking care for back pain, your chiropractor may provide an estimate that includes an initial consultation (\$180), spinal adjustment (\$70 per session), X-rays (\$60 per area), Ice Pack \$15, Cryoderm \$15. This estimate is not a bill but gives you a clear idea of expected charges before services are provided. If you receive a bill that is at least \$400 more than this estimate, you have the right to dispute it.

Chiropractic Informed Consent to Treat:

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 the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories of this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed 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 on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had 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) for which I seek treatment.

Print Name _____ Date _____

Signature _____