

Personal Information

Date of Birth ____/____/____ Sex: M F Date ____/____/____

Name _____

Address _____ City _____

State _____ Zip _____ Email _____

Phone(H) _____ Phone(W) _____ Cell _____

Marital Status S M D W Spouse's Name _____

Number of Children _____ Ages _____

Insurance Policy Holder's Name _____

Policy Holder's DOB ____/____/____ Relationship to Patient _____

REFERRED BY _____

Emergency Contact

Name _____

Relationship _____

Phone # s _____

INSURANCE

We only participate with MEDICARE. However, we can submit your insurance as an out of network provider. If your insurance does not pay, the balance would be your responsibility.

I _____ have read the above and understand completely.

Signature _____ Date ____/____/____

Confidential Health History

Name _____ Date _____

Age _____ DOB: _____ Occupation _____

Reason for consulting our office:

- Pain (explain) _____
- Disability (explain) _____
- What would you like to improve? _____
- To Continue Wellness Care _____

If you are experiencing pain, is it:

sharp ___ dull ___ numb ___ comes and goes ___ travels ___ constant ___

When did it start? _____ Have you had it before? ___ when _____

Have you seen a Chiropractor before? When/Where _____

Since it started is it: better ___ same ___ worse ___

What makes it better? _____

What makes it worse? _____

Does problem interfere with: work ___ sleep ___ daily activity _____

standing ___ sitting ___ walking ___ lifting ___ stairs ___ reaching ___

bending ___ hobbies _____

Home remedies _____

Other Doctors you've seen for this _____

List surgeries and when _____

List any car accidents and when _____

List any major falls and when _____

List any broken bones and when _____

List any nutritional supplements _____

List medications you are taking _____

List any family health concerns _____

Sleep position: Stomach ___ Back ___ Side ___

Do you: Smoke ___ Wear arch supports/orthotics ___ Drink water ___

Rate (1-bad 10-excellent) your:

Health ___ Diet ___ Exercise ___ Flexibility ___

Sleep ___ Handle stress ___ Attitude ___ Outlook on life ___

How do you like to spend your free time? _____

As a result of my Chiropractic Care, I would like to:

Feel better quickly ___ Have a healthier body and Nervous System _____

Have a healthier spine ___ Live a healthier lifestyle _____

**** Please See Other Side ****

Please circle ALL that apply

PHYSICAL STRESS **AS A** **CHILD TEEN ADULT**

<u>Birth Trauma</u>	<u>C</u>	<u>Γ</u>	<u>A</u>
<u>Poor Posture</u>	<u>C</u>	<u>Γ</u>	<u>A</u>
<u>Excessive Computer work</u>	<u>C</u>	<u>Γ</u>	<u>A</u>
<u>Sports Injuries</u>	<u>C</u>	<u>Γ</u>	<u>A</u>
<u>Carrying purse/child</u>	<u>C</u>	<u>Γ</u>	<u>A</u>
<u>Continuous sitting/stand</u>	<u>C</u>	<u>Γ</u>	<u>A</u>
<u>Driving many hours</u>	<u>C</u>	<u>Γ</u>	<u>A</u>
<u>Balance Problems</u>	<u>C</u>	<u>Γ</u>	<u>A</u>
<u>Hearing Problems</u>	<u>C</u>	<u>Γ</u>	<u>A</u>
<u>Eye Problems</u>	<u>C</u>	<u>Γ</u>	<u>A</u>
<u>Teeth Problems</u>	<u>C</u>	<u>Γ</u>	<u>A</u>
<u>Physical abuse</u>	<u>C</u>	<u>Γ</u>	<u>A</u>
<u>Work</u>	<u>C</u>	<u>Γ</u>	<u>A</u>

CHEMICAL STRESS

<u>Second hand smoke</u>	<u>C</u>	<u>Γ</u>	<u>A</u>
<u>Poor Diet</u>	<u>C</u>	<u>Γ</u>	<u>A</u>
<u>Caffeine – amount</u>	<u>C</u>	<u>Γ</u>	<u>A</u>
<u>Excessive sugar</u>	<u>C</u>	<u>Γ</u>	<u>A</u>
<u>Artificial sweeteners</u>	<u>C</u>	<u>Γ</u>	<u>A</u>
<u>Prescription drugs</u>	<u>C</u>	<u>Γ</u>	<u>A</u>
<u>Counter drugs Tylenol, Tums</u>	<u>C</u>	<u>Γ</u>	<u>A</u>
<u>Environmental Pollution (air, water)</u>	<u>C</u>	<u>Γ</u>	<u>A</u>

EMOTIONAL STRESS

<u>Relationships</u>	<u>C</u>	<u>T</u>	<u>A</u>
<u>Career</u>	<u>C</u>	<u>T</u>	<u>A</u>
<u>Children</u>	<u>C</u>	<u>T</u>	<u>A</u>
<u>Money</u>	<u>C</u>	<u>T</u>	<u>A</u>
<u>Fast Pace Life</u>	<u>C</u>	<u>T</u>	<u>A</u>
<u>Internalized Feeling</u>	<u>C</u>	<u>Γ</u>	<u>A</u>
<u>Perfectionist</u>	<u>C</u>	<u>T</u>	<u>A</u>
<u>Procrastinator</u>	<u>C</u>	<u>T</u>	<u>A</u>
<u>Sickness or Loss of loved one</u>	<u>C</u>	<u>T</u>	<u>A</u>
<u>Quick Temper</u>	<u>C</u>	<u>T</u>	<u>A</u>
<u>Verbal Abuse</u>	<u>C</u>	<u>T</u>	<u>A</u>

Which do you feel is your Primary Stress :
Physical ___ Chemical ___ Emotional ___

The statements made on this form are accurate to the best of my knowledge,
and I agree to allow this office to examine me for further evaluation.

Signature _____ Date _____



Cheff Chiropractic Care

DR. JOSEPH P. CHEFF

RELEASE OF INFORMATION

By signing this form, you are granting consent to Cheff Chiropractic Care and disclose your protected health information for the purposes of treatment, payment and health operations. Our notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at (540)459-3900. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we decide to grant your request, we are bound by our agreement.

Signature Date

MEDICARE CONSENT TO RELEASE INFORMATION

I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare claim.

Signature Date

VERIFICATION OF NON PREGNANCY (Female patients only)

By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____

Signature Date

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature Date

MEDICAL AUTHORIZATION

I, _____ do hereby authorize you to release any and all information concerning myself, including x-rays, medical reports, clinical reports, or other related documents acquired in the course of my examination understanding they are a part of your permanent records.

Signature Date

118 Fairground Road • Woodstock, Virginia 22664 • Telephone (540) 459-3900



Cheff Chiropractic Care

DR. JOSEPH P. CHEFF

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working toward the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. Regardless of what disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. **Our ONLY practice objective is to eliminate a major interference to the nervous system and thus improve the expression of the body's innate wisdom.** Our only method of doing so is the specific adjustment of the spine to correct vertebral subluxations. It is important that you, the patient, understand the specific terms used to describe this goal. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

I, _____ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature

Date

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Office Fee Schedule and Financial Policy

Consultations	No Charge	No Charge
Initial Exam w/Scan	\$110.00	\$80.00
X-Rays (per view)	\$30.00	\$25.00
Periodic Dynamic Exam	\$30.00	\$15.00
Adjustment	\$45.00	\$40.00
Therapeutic/Rehab Services	\$20.00	\$15.00
Wellness Adjustment Plans	Not Applicable	\$70.00 - \$480.00

Financial Policy and Chiropractic Active Life Plans

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time of service unless you arrange a Chiropractic Active Life Plan in advance. These plans are designed to be the most cost effective way to keep you and your family as healthy as possible. They include Corrective Adjustment Plans (CAP) and Wellness Adjustment Plans (WAP). Details of these plans will be discussed with you during your chiropractic report.

Please choose one of the following fee options:

Regular Fees: If you have health insurance that covers chiropractic and choose to use it, you will be charged the regular fees listed above. We will file the insurance claim for you, but please remember that in the event of a dispute, your agreement with your insurance company is between you and them. Any unpaid balances remaining after your insurance claim has been processed will be billed to you. Please note that insurance may not be used for Wellness Adjustment Plans.

Time of Service Discounted Fees: If you do not have health insurance, choose not to use your health insurance or are participating in a Wellness Adjustment Program, you will be eligible for the time of service discounted fees above. You will be given a receipt for tax purposes or a health savings account (HSA) indicating the total amount you have paid for chiropractic care during the year. There is no insurance documentation given with these receipts.

If a special situation arises, such as an auto accident or a worker's compensation injury, you will be charged our regular fees until the claim is settled. We will help you get reimbursed as quickly as possible on these claims. Once the claim is complete, you can begin to pay the discounted fees again.

I, _____ have read and I understand the above policies. I have initialed the fee option that applies to me.

Signature

Date

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