Life Point
Chiropractic & Wellness Center

Welcome to Life Point & The Office of Dr. Alex Markel B.S., D.C.

Today's Date:_____/_____/_____

Name: _____ Age_____ Date of Birth_____/_____/_____

Local Address_____ City_____ State____ Zip_____

Out of Town Address_____ City_____ State____ Zip_____

Home Phone (____)_____-_____ Cell. Phone (____)_____-_____

Marital Status_____ Sex_____ S.S.# _____-____-_____

Spouse Name _____ Contact Phone: (____)_____-_____

Email Address: _____

Employer_____

Occupation _____ Employer: _____ Address/Phone _____

Emergency Contact_____ Phone(____)_____-_____ Relationship_____

How did you hear about our office?

◯ Yellow Pages ◯ Drive By ◯ Walk-In ◯ Internet ◯ Referral (Please tell us who) _____ ◯ Other: _____

Health Insurance Information

Primary Insurance _____

Policy Holder's Name _____ DOB _____/_____/_____

Policy Holder's Relationship to Patient _____

Policy Holder's Employer _____

Accident Information (SKIP this section if you were not involved in an accident)

Is your condition due to an: ***Auto Injury Work Injury Slip and Fall Other Accident (describe below)***

Date of Accident_____ Place (City/State)_____

Auto/Work Insurance Company_____ Insured's Name and DOB_____

If Auto Injury, have you reported the accident to your insurance company? ◯ No ◯ Yes Claim #_____

If Work Injury, have you reported the accident to your supervisor/boss? ◯ No ◯ Yes Claim #_____

If Slip and Fall or Other Type of Injury, please describe:

_____

_____

*Do you have an **Attorney** for your Auto or Work Comp. injury?* ◯ No ◯ Yes

Please provide Attorney Name, address and phone #

_____

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CURRENT COMPLAINT

I. Please list your **worst** complaint: _____ How long have you had it: _____

How did it start: _____ ***A) Is it:*** *Improving Worsening Staying the Same* ***B) Is it:*** *Mild Moderate*

Severe ***C) What worsens it:*** *General activity Moving Wrong Bending Lifting Walking Sports Getting up from a chair*

Using a computer/desk work Other: _____ ***D) What makes it better:*** *Rest General Activity Ice Packs*

Heating Pad OTC Meds Rx Meds Massage Chiropractic Other:_____ ***E) Is it worse in the:*** *AM PM*

After day wears on Steady Off and on ***F) Is the symptom:*** *Dull and Achy Tight and Stiff Sharp and Stabbing*

Numb and Tingly Shooting Burning Cramping

II. Please list your **2nd worst** complaint: _____ How long have you had it: _____

How did it start: _____ ***A) Is it:*** *Improving Worsening Staying the Same* ***B) Is it:*** *Mild Moderate*

Severe ***C) What worsens it:*** *General activity Moving Wrong Bending Lifting Walking Sports Getting up from a chair*

Using a computer/desk work Other: _____ ***D) What makes it better:*** *Rest General Activity Ice Packs*

Heating Pad OTC Meds Rx Meds Massage Chiropractic Other:_____ ***E) Is it worse in the:*** *AM PM*

After day wears on Steady Off and on ***F) Is the symptom:*** *Dull and Achy Tight and Stiff Sharp and Stabbing*

Numb and Tingly Shooting Burning Cramping

MEDICARE PATIENTS (check one): Would you like to be able to:

- ◯ *Bend and lift with no pain,*
- ◯ *Get up from sitting with no pain,*
- ◯ *Get a good night's sleep with no pain*
- ◯ *Read with no pain*
- ◯ *Work at a computer with no pain*
- ◯ *Do your housework with no pain*
- ◯ *Do your yard work with no pain*
- ◯ *Play sporting activities with no pain*

Current Health

• Name and phone number of family doctor:

_____

• List all CURRENT illnesses or diseases you have been diagnosed with (cancers, tumors, infections, diabetes, aneurysms, etc.): _____

Date of late eye exam: _____/_____/_____

• If you are currently taking any prescription or nonprescription medications, please list them below with dosages:

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Medication: _____ Dose: _____ Medication: _____ Dose: _____

• Please list any medications you are allergic to:

_____

• Please indicate your height and weight _____What is your usual blood pressure_____/_____

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Health History

• List any operations, surgeries or medical procedures:

Date:___/_____/___ Procedure: _____ Date___/_____/___ Procedure: _____

Date___/_____/___ Procedure: _____ Date___/_____/___Procedure: _____

• If you have ever had in the past or currently have any serious illnesses or injuries, please list:

Date___/_____/___ Condition: _____ Date___/_____/___ Condition: _____

Date: ___/_____/___Condition: _____ Date: ___/_____/___ Condition: _____

Any current loss of bowel or bladder control: ◯ Yes ◯ No

Any current seizures, paralysis, speech, vision problems: ◯ Yes ◯ No

Any unexplained recent weight loss: ◯ Yes ◯ No

Current fever: ◯ Yes ◯ No

Current nutritional problems: ◯ Yes ◯ No

• Please list any significant family illnesses_____

• Have you had spinal X-Rays within the past 5 years? If yes, when and where _____

• **Do you have a pacemaker? ◯ Yes ◯ No If yes, please ALERT our doctor and/or chiropractic assistant**

• Do you have any blood/lymph disorders? ◯ Yes ◯ No If yes, please list _____

• Do you have osteoporosis or rheumatoid arthritis? ◯ Yes ◯ No

• Please list any other electrical device that you currently wear_____

• Please select one: I have never smoked Former smoker Current smoker, if so how much: ____ pk./day ____ pk./wk.

• Please select one: I don't drink alcohol Rarely drink Social drinker Heavy drinker (_____ oz. per day/week)

• Have you ever had chiropractic care Yes No If yes, last date of treatment_____ By whom: _____

Similar or difference condition:_____ Results: _____

What are your overall expectations from your treatment with our doctor: _____

I, the undersigned, hereby give my consent for the doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic care. I also give my consent to the doctor to take x-rays (if needed) or to perform other diagnostic aids as he/she deems appropriate in my case.

• ***WOMEN ONLY*** *I hereby declare that to the best of my knowledge* ***I am I am not pregnant****. If there is a chance that I may be pregnant, I will inform the doctor prior to my examination.*

Patient Signature_____
(Parent/Guardian signature if under 18 years of age)

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GENERAL/FINANCIAL POLICY

Welcome to Life Point Chiropractic & Wellness Center. We strive to provide you with excellent Chiropractic care in a clean, friendly, professional setting and our goal is to make your visits as convenient as possible.

By signing below, you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone number changes.
- Your account is to be kept current. All self-pay or insurance copayments, co-insurances and deductibles will be collected at the time of service payable by cash, check, Visa, MasterCard, Discover, American Express or Care Credit.
- If you do not have your payment (s), your appointment may be rescheduled.
- If you are unable to keep a scheduled appointment, please notify us no later than the day before so that we may offer that time to another patient.
- **There is a $25.00 charge for missing an appointment without notice.**
- A returned check will result in a $25.00 service charge and all future payments being required in the form of cash or credit card.
- You will only be sent a statement if your balance exceeds $5.00.
- There is a $35.00 charge for the completion of paperwork (ex: disability, FMLA, etc).
- If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 35% of your outstanding balance, court costs and attorney fees.

IF YOU HAVE HEALTH INSURANCE COVERAGE: As a courtesy to you, our office will attempt to pre-verify your primary insurance coverage for your Chiropractic care. Coverage information is obtained from your insurance company using information provided by you prior to your initial visit. **We must emphasize that as medical providers, our relationship is with you, not your insurance company.** Please be advised that the information provided by your insurance company is not a guarantee of payment, only an estimate of what might be covered under your policy at the time of inquiry.

By signing below you confirm you understand that:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified.
- Not all services are a covered benefit with all insurance plans.
- It is your responsibility to be aware of what service (s) is being provided to you and if it is a covered benefit under your insurance.
- You are responsible for any non-covered charges not payable by your insurance policy.
- We will send all required claim forms and documentation to ensure your claims are processed in a timely manner.
- Final determination of benefits available is determined when the claim is sent to your insurance company and we receive an
- explanation of benefits from them.
- After all co-pays, contracted plan reductions and insurance payment credits are applied to your account, any remaining portion will be your responsibility.
- If you are a **MEDICARE PATIENT**, please be advised that Medicare **only covers** Spinal Adjustments in a Chiropractor's office. All services outside of the Spinal Adjustment in our office will be your financial responsibility.

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- We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, *please* do not hesitate to ask us. **WE ARE HERE TO HELP YOU.**

By signing below, you have read and understand the above Financial Policy and agree to meet all financial obligations.

_____ _____/_____/_____

Printed Name Signature of Patient/Legal Guardian Date

CONSENT TO TREAT A MINOR: I hereby authorize and give consent for the Chiropractic Physicians at Advanced Spinal Care of Lakeland to examine, and if needed, treat my minor child _____.(Print child's name here)

_____ _____/_____/_____

Printed Name Signature of Patient/Legal Guardian Date