Active Life
CHIROPRACTIC &
PHYSICAL THERAPY

CHIROPRACTIC INTAKE FORM

PATIENT INFORMATION:

EMAIL ADDRESS:_____

FIRST NAME:	LAST NAME:	MIDDLE INITIAL:	TODAY'S DATE:
ADDRESS:	CITY:	STATE:	ZIP:
BIRTH DATE : / /	AGE:	☐ MALE ☐ FEMALE	S.S.#: - - *(VETERANS ONLY)
HOME #: ( ) -	MOBILE #: ( ) -	SPOUSE NAME:	
HOW DID YOU FIND OUT ABOUT US:		SPOUSE #: ( ) -	

WORK INFORMATION:

EMPLOYER:	WORK #: ( ) -	EXT:
OCCUPATION:		

CARE PROVIDER INFORMATION:

REFERRING DR:	REFERRING DR #:
REGULAR DR./PCP:	REGULAR DR./PCP#:

INSURANCE INFORMATION:

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

PRIMARY INSURANCE NAME:	
SUBSCRIBER'S NAME (IF DIFFERENT):	BIRTH DATE: / /
ID#:	GROUP/POLICY #:
PATIENT'S RELATIONSHIP TO SUBSCRIBER : ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER:	

IN CASE OF EMERGENCY:

NAME OF LOCAL FRIEND OR RELATIVE:		
RELATIONSHIP TO PATIENT:	HOME#: ( ) -	MOBILE#:( ) -

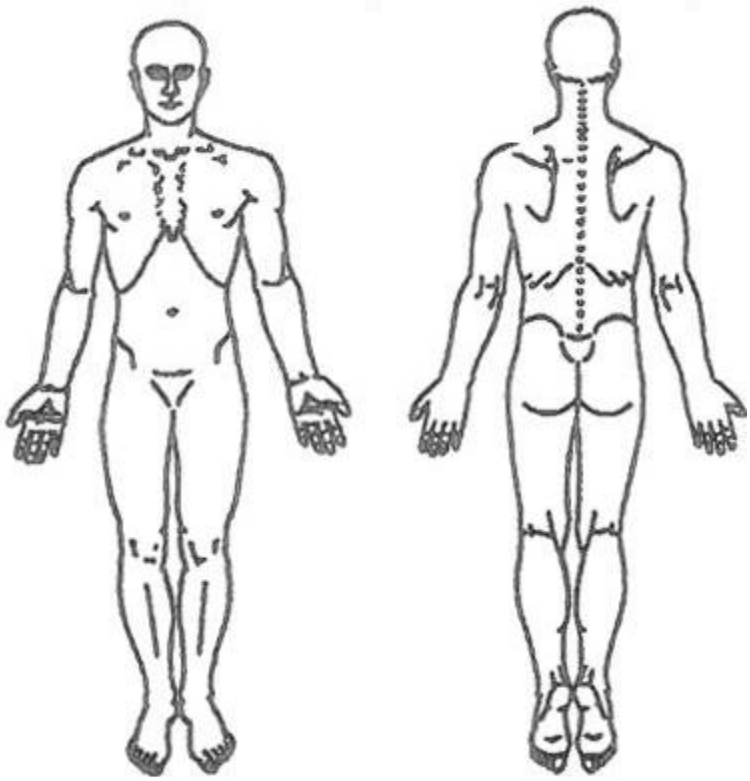
I AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO ACTIVE LIFE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE. I ALSO AUTHORIZE ACTIVE LIFE TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS.

_____

PATIENT / GUARDIAN SIGNATURE **DATE**

PAIN AND SYMPTOMS STATUS REPORT:

PLEASE CIRCLE AREAS WHERE YOU ARE HAVING PAIN:



CHIEF COMPLAINT AND VISUAL ANALOG SCALE:

MY CHIEF COMPLAINT IS:_____

_____

2ND COMPLAINT: _____

_____

CIRCLE ON THE SCALE BELOW TO INDICATE YOUR CURRENT LEVEL OF PAIN:

NO PAIN 1 2 3 4 5 6 7 8 9 10 PAIN AS BAD AS IT GETS.

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INSURANCE RESPONSIBILITY

Your insurance agreement is between you and the insurance company. The services we provide are due and payable at the time of service. As a courtesy, we allow our patients to use their insurance coverage in our clinic.

Please be advised that, if, for any reason your INSURANCE CARRIER denies claims for services we provided you, YOU are RESPONSIBLE for paying off the outstanding or disputed amounts.

If we have issues with your insurance claims, because Active Life was not notified of the change of coverage/information by you, the patient, or you have reached your maximum visits allowed and the claims are denied, we will no longer honor the insurance coverage and you will need to be on a CASH BASIS ONLY.

I HAVE READ AND FULLY UNDERSTAND THAT I AM EXPECTED TO MAKE SURE MY INSURANCE COVERAGE PROVIDED IS CORRECT AND UPDATED WHEN CHANGES ARE MADE. I ACCEPT RESPONSIBILITY FOR OUTSTANDING CLAIMS AND AMOUNTS.

PRINT NAME: _____

_____

Patient Signature **Date**

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MISSED APPOINTMENT POLICY

DUE TO THE THOROUGHNESS OF OUR CARE, WE SPEND A GREAT AMOUNT OF TIME ON OUR PATIENTS. IN ORDER TO HAVE ADEQUATE TIME FOR OUR PATIENT CARE, WE CAREFULLY SCHEDULE YOUR APPOINTMENTS. WE DO THIS BECAUSE WE VALUE YOUR TIME AS WELL AS OUR OWN TIME.

ONCE WE HAVE MADE AN APPOINTMENT FOR YOU, WE HAVE RESERVED A CERTAIN AMOUNT OF TIME FOR YOU ON THAT VISIT. IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, YOU ARE REQUIRED TO GIVE US AT LEAST A 4 HOUR NOTICE OF A CANCELLED APPOINTMENT.

EFFECTIVE IMMEDIATELY THERE WILL BE A $20 FEE FOR MISSED APPOINTMENTS.

I HAVE READ AND FULLY UNDERSTAND THAT I AM EXPECTED TO KEEP MY APPOINTMENTS. I AGREE THAT IF I MISS A SCHEDULED APPOINTMENT WITHOUT NOTIFYING YOUR OFFICE AT LEAST 4 HOURS IN ADVANCE, I AM REQUIRED TO PAY A $20 MISSED APPOINTMENT FEE.

PATIENT SIGNATURE **DATE**