7521 Virginia Oaks Drive #240
Gainesville, VA 20155
PH: 703-753-7600
FAX: 703-753-8070

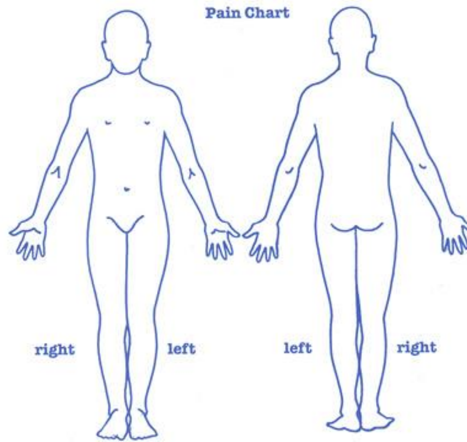
PATIENT REGISTRATION FORM

NAME			HOME #
ADDRESS			WORK #
CITY-STATE-ZIP			EMAIL
NAME YOU PREFER TO BE ADDRESSED AS	DATE OF BIRTH	SS #	REFERRED BY

PLEASE INDICATE PRIMARY COMPLAINT (E.G. HEADACHES, PAIN IN NECK, LOW BACK, FOOT ETC.)

____

USE THE LETTERS LISTED BELOW TO INDICATE THE *TYPE* AND *LOCATION* OF YOUR PAIN AND SENSATIONS... (E.G. IF YOU HAVE A STABBING PAIN IN YOUR NECK, MARK AN "S" ON THE NECK WHERE THE PAIN IS)



KEY
- **A** = ACHE
- **B** = BURNING
- **S** = STABBING
- **N** = NUMBNESS
- **P** = PINS & NEEDLES
- **O** = OTHER

IS THIS THE FIRST TIME YOU HAVE EXPERIENCED THIS PAIN, OR IS IT RECURRENT? ◯ FIRST ◯ RECURRENT

IF RECURRENT, HOW OFTEN DOES IT RECUR (4X/DAY, 1X/MONTH, 2X/YEAR ETC)? ____________________

IF RECURRENT, WHEN DID THIS PARTICULAR EPISODE BEGIN? ____________________

WHEN THE FIRST TIME YOU EVER SUFFERED FROM THIS COMPLAINT? ____________________

WHAT DO YOU THINK WAS THE CAUSE OF YOUR PAIN? (E.G. CAR ACCIDENT, OCCUPATION ETC.) ____________________

____

WHAT DECREASES YOUR PAIN? (E.G. PAIN MEDICATION, ICE, HEAT, LAYING DOWN, STRETCHING ETC.)

____

WHAT INCREASES YOUR PAIN? (E.G. SITTING TOO LONG, READING, WALKING, BENDING ETC.)

____

HAVE YOU EXPERIENCED ANY NUMBNESS, PAIN, WEAKNESS OR TINGLING IN YOUR ARMS, HANDS, LEGS OR FEET?

◯ YES ◯ NO IF YES, WHERE? ____________________

PLEASE MARK A VERTICAL LINE (|) ON THE LINE BELOW TO INDICATE THE SEVERITY OF YOUR PAIN (0= NO PAIN ... 10= MOST SEVERE PAIN IMAGINABLE)

____

0 **10**

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PLEASE LIST ANY OTHER TREATMENT THAT YOU HAVE EVER RECEIVED FOR YOUR PRIMARY COMPLAINT:

DOCTOR'S NAME AND PHONE #	MRI/X-RAY RESULTS	TYPE OF TREATMENT GIVEN AND THE RESULTS OF THE TREATMENT
DOCTOR'S NAME AND PHONE #	MRI/X-RAY RESULTS	TYPE OF TREATMENT GIVEN AND THE RESULTS OF THE TREATMENT
DOCTOR'S NAME AND PHONE #	MRI/X-RAY RESULTS	TYPE OF TREATMENT GIVEN AND THE RESULTS OF THE TREATMENT

HAVE YOU BEEN INVOLVED IN ANY RECENT TRAUMA (FALL, ACCIDENT ETC.) ◯ YES ◯ NO

IF YES, PLEASE DESCRIBE: ______________________________

DO ANY OF THE FOLLOWING APPLY TO YOU:

	YES	NO		YES	NO
LOSS OF STRENGTH	◯	◯	UNEXPLAINED WEIGHT LOSS	◯	◯
LOSS OF BLADDER/BOWEL CONTROL	◯	◯	FEVER (OVER 101), CHILLS	◯	◯
USE OF PRESCRIPTION STEROIDS	◯	◯	IV DRUG USE	◯	◯
WORSE PAIN AT NIGHT OR WHEN LYING	◯	◯	NIGHT SWEATS	◯	◯

HAVE YOU EVER HAD:

◯ ASTHMA	◯ BLEEDING PROBLEMS	◯ BLOOD CLOTS	◯ CANCER
◯ COPD	◯ DEPRESSION	◯ DIABETES	◯ HEART DISEASE
◯ HEPATITIS	◯ HIGH BLOOD PRESSURE	◯ HIGH CHOLESTEROL	◯ HIV
◯ KIDNEY DISEASE	◯ LIVER DISEASE	◯ LUNG DISEASE	◯ MENTAL ILLNESS
◯ OSTEOPOROSIS	◯ STROKE	◯ OTHER______________________	

IS THERE A CHANCE YOU MAY BE PREGNANT? YES ◯ NO ◯

PLEASE LIST ANY MEDICATIONS YOUR ARE TAKING AND THE CONDITION THAT YOU ARE TAKING THEM FOR:

____

____

____

- **I, THE UNDERSIGNED, WHOSE NAME APPEARS ABOVE, HEREBY CONSENT TO AND AUTHORIZE ALL DIAGNOSTIC AND THERAPEUTIC TREATMENTS CONSIDERED NECESSARY OR ADVISABLE IN THE JUDGEMENT OF THE ATTENDING PHYSICIAN.**
- **I AUTHORIZE PAYMENT OF ANY MEDICAL BENEFITS FROM MY INSURANCE COMPANY TO BE PAID DIRECTLY TO RESULTS REHABILITATION. FOR ANY SERVICE RENDERED TO ME**
- **I ACKNOWLEDGE THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF MY BILL, INTEREST CHARGES AND ANY SERVICE CHARGES THAT ARE INCURRED IN COLLECTING PAYMENT FOR MY BILL**

Patient's Name: ______________________________

Name of Parent/Guardian/Authorized Representative: ______________________________

Patient's Signature: ______________________________

Signature of Parent/Guardian/Authorized Representative: ______________________________

Date of Signature: ________/________/____________

Date of Signature: ________/________/____________

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Chiropractic Informed Consent to Treat

I hereby request and consent to diagnosis and treatment by Kevin Maggs DC, including various modes of physical medicine, chiropractic adjustments, diagnostic imaging, and any supportive therapies on me, or on the patient named below, for whom I am legally responsible.

I have had an opportunity to discuss with the Kevin Maggs D.C. and/or with other office or clinic personnel the nature and purpose of his diagnosis, treatments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there no promise of cure. I further understand and am informed that, as in practice of medicine, the practice of chiropractic includes some risks of treatment which are rare, including, but not limited to, pain and tissue soreness, fractures, disc injuries and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications, and 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 known, is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedure. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other options if I have concerns as to the nature of my symptoms and treatment options.

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 procedure. 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.

Patient's Name:	Name of Parent/Guardian/Authorized Representative:
______________________________	______________________________
Patient's Signature:	Signature of Parent/Guardian/Authorized Representative:
______________________________	______________________________
Date of Signature:	Date of Signature:
______/______/____________	_____/______/____________

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Cancellation Policy

Please notify us 24 hours in advance if you are unable to keep a scheduled appointment. The charge for the missed appointment or no-show will be **$50.00.** We have a recorder for your convenience, so you may leave a message for the next business day.

A broken appointment affects three people…

1. The patient who missed the appointment
2. Other patients who could have used that appointment time
3. The chiropractor and staff who were present and prepared for the appointment

Print Patient's or Responsible Person's Name: ______________________________

Signature: ______________________________ Date: _____/______/________

Medical Information Release Form (HIPAA Release Form)

Release of Information

○ I authorize the release of all medical information rendered to me by Lively Health, LLC. This information may be released to:

○ Spouse____________________ ○ Child(ren) __________________

○ Other healthcare providers ○ Other ______________________________

○ Information is not to be released to anyone without my consent.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call ○ my home ○ my work ○ my cell number

If unable to reach me:

○ You may leave a detailed message.

○ Please leave a message asking me to return your call.

I authorize email communication to the following email address: ______________________________

I acknowledge that the I have been given the option to view Notice of Privacy Practices for this office

Patient's Name:

____

Name of Parent/Guardian/Authorized Representative:

____

Patient's Signature:

____

Signature of Parent/Guardian/Authorized Representative:

____

Date of Signature:

______/______/________

Date of Signature:

______/______/________

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Office Policy and Assignment of Payments

Appointments:
- Lively Health LLC tries to maintain an excellent record of punctuality. In return, we expect that our patients present to their appointments in a timely fashion. Your appointment will start at the designated time and finish at the designated time. For example, if you have a 30 minute appointment and you present 10 minutes after the appointment begins, you will be seen for the remainder of the 20 minutes. Otherwise, the patients that follow you will have to wait. We don't value either option.
- Infrequently, we may be running late because a patient before needed extra time. In the case when we are running behind, you will still have you full allotted time.
- We can, at times, work-in an urgent or emergency visit, but previously scheduled patients have priority.

Payment Policy:
- Any required payments are expected at the time of each visit.
- If the insurance company does not pay in full, according to the terms of the patient's policy, the patient will be responsible for all unpaid charges.
- It is the patient's responsibility to keep track of the dollar amount limits, number of authorized visits (if necessary), changes for co-payments, deductibles, etc. for their insurance policy.
- Lively Health LLC will call to verify your insurance benefits at the time of your initial visit, however, as stated by your insurance company "these are an estimate of benefits and not a guarantee of payment". Ultimately, it is your responsibility to verify your benefits.

HMO/POS/PPO Referrals/Authorization:
- We do not participate in any HMO's
- If an insurance company requires a referral or preauthorization, this referral needs to be received by our office before the patient is seen. Obtaining this initial referral is the patient's sole responsibility and all charges incurred due to improper referral procurement will also be the patient's responsibility.
- If an insurance company requires an additional referral or authorization for further treatment, Lively Health LLC will provide the patient with the necessary documentation, or we will fax it directly to the insurance company or primary care doctor's office. However, it is ultimately the patient's responsibility to obtain the referral or authorization.

As a courtesy to our patients, we will submit medical claims to your primary and secondary insurance. In signing this form, you agree that we may bill your insurance company on your behalf, and you agree to ASSIGN PAYMENTS to "Results Rehabilitation". This means that you give permission for the insurance payments to be made directly to us. If you do not agree to this, we require payment directly from you at the time of service, and we will then provide you with the necessary documentation to file your own insurance papers.

I have read the above agreement. I understand and agree to all of the points discussed above.

Patient's Name: ______________________________

Name of Parent/Guardian/Authorized Representative: ______________________________

Patient's Signature: ______________________________

Signature of Parent/Guardian/Authorized Representative: ______________________________

Date of Signature: _______/_______/__________

Date of Signature: _______/_______/___________