Patient #: _____(office use only)

VALLEY SPINAL CARE

PATIENT INFORMATION (Please Print) :

Full Name _____ Nickname _____

Address _____ City_____ State_____ Zip_____

Phone: Home _____ Mobile _____ Text messages: **YES NO**

SS# _____-_____-_____ Date of Birth _____

Employer _____ Work Phone _____

Email _____ *How did you hear about us?*_____

Spouse/Guardian _____ Phone #_____

Emergency Contact_____ Relationship _____ Phone # _____

AUTHORIZATION FOR HEALTH CARE SERVICES:

I authorize Valley Spinal Care (VSC) to administer chiropractic care, including but not limited to examinations, adjustments, x-rays, and therapies.

X-RAYS: It is understood and agreed the amount paid VSC for x-rays is for examination only and the originals will remain the property of this office. An x-ray report will be provided to another physician at no charge. If copies of x-rays are required, I will be responsible for the x-ray print fee of $5.00 per X-ray or $10 for CD, which will be available within three (3) days after the date of request.

Signature _____ **Date**_____

***NOTE FOR WOMEN*: It is *very important* to inform the doctor or staff if you are pregnant. _____**

FEES FOR SERVICES RENDERED:

There is no fee for consulting with the doctor. Fees begin when a spine related problem is found and you decide to receive care from the doctor.

New Patient (Adult)		New Patient (Child - 16 years & under)	
History/Examination/Report of Findings (99203)	185.00	History/Examination/Report of Findings (99203)	90.00
Cervical X-rays (72050)	195.00	Cervical X-rays (72050)	175.00
Initial Spinal Correction (98940)	65.00	Initial Spinal Correction (98940)	35.00
TOTAL	$445.00	TOTAL	$300.00

***Full Spine X-rays additional **150.00 **Not all patients will have full spine x-rays. Charges will reflect services rendered.*

Routine Office Visits

Spinal Examination without adjustment $55.00 With an Adjustment $65.00

Established Patients

Re-exams will take place at approximately 1 and 3 months of your initial care if needed or requested. These will assist the doctor in determining your progress, modification of diagnosis and further treatment plan recommendations. The charges for these visits are estimated below.

1-Month Re-Exam Charges include re-exam, self care training, and lateral cervical x-ray

3-Month Re-Exam Charges include re-exam and lateral cervical x-ray

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

Your insurance policy is a contract between you and your carrier. These days, many policies reimburse for at least *some* chiropractic care. But coverage varies from policy to policy. And constantly changes. Our goal is to help you get well and *stay* well. Sometimes this is at odds with the profit motives of an insurance company. This is frustrating for you, them and us.

To protect our freedom to recommend what's truly best for you, we don't attempt to serve two masters. It's your health and you're the boss. So, we do not take insurance assignment. Instead, payment for our services will be your responsibility. We will explain the purpose of every procedure. We will supply you with the documents you'll need for filing a claim with your insurance company. Please note that some of our services may not be reimbursable under your policy.

*** *** ***

I accept financial responsibility for my care. I understand that fees are payable when services are rendered, unless other arrangements have been made in advance. I understand that any cancelations less than 24 hours in advance, I may still be responsible for. I instruct this office to deliver the care that, in their judgment, can best help me in the restoration of my health.

Signature _____ **Date**_____