



THE BACK CENTER & ASSOCIATES, LLC.

CONFIDENTIAL PATIENT INFORMATION

Name: _____ Today's Date: _____
 Social Security #: _____ - _____ - _____ Date of Birth: ____/____/____ Age: _____ Sex: M / F
 Address: _____ City: _____
 State: _____ Zip: _____ E-Mail: _____
 Home Phone: (____) _____ Cell Phone: (____) _____
 Emergency Contact: _____ Relationship: _____
 Phone: (____) _____ Marital Status: Single Married Divorced Widowed

Employer: _____ Occupation: _____
 Employer's Address: _____ City: _____
 State: _____ Zip: _____ Business Phone: (____) _____
 May we confirm appointments at this number? Y / N

Who referred you to our office? _____
 Personal Physician: _____ Specialty: _____
 Phone #: (____) _____ Date & Place of last physical: _____
 Have you seen any other Chiropractor, Physical Therapist or Acupuncturist? Yes No
 If yes, please list: _____

Health Insurance Carrier: _____
 Name of Insured: _____ Insured's D. O. B.: ____/____/____
 Insurance ID #: _____ Group #: _____ Effective Date: ____/____/____
 Are you covered on any other policy (spouse, parent, etc?) Yes No
 If yes, please list secondary health insurance carrier: _____
 Name of Insured: _____ Insured's D. O. B.: ____/____/____
 Insurance ID #: _____ Group #: _____ Effective Date: ____/____/____

I understand & agree that health & auto insurance policies are strictly an arrangement between an insurance carrier & me. Furthermore, I understand that Dr. David J. Gilligan, DC will prepare any necessary reports & forms to assist me in making collection from the insurance company, & that any amount authorized to be paid directly to Dr. David J. Gilligan, DC will be credited to my account upon receipt. However, I clearly understand & agree that all services rendered to me are charged directly to me & that I am personally responsible for payment. Balances after 30 days will be charged at a rate of 1-1/2 % interest. The patient will be responsible for any legal expenses involved in collection of past due accounts.

Patient's Signature _____ Date: ____/____/____
 Guardian's Signature, if minor _____ Date: ____/____/____

Were you previously treated for a different occurrence of this same condition? Yes No

If yes, by a: Chiropractor M.D. Therapist Other: _____

Please specify dates with treatment results: _____

What makes your problem worse? Nothing Laying Down Walking Standing

Sitting Movement/Exercise Inactivity Other: _____

How would you grade your stress level? None Minimal Moderate Greatly Stressed

Physical activity at work: Sit more than 50% of the day Light Manual Labor

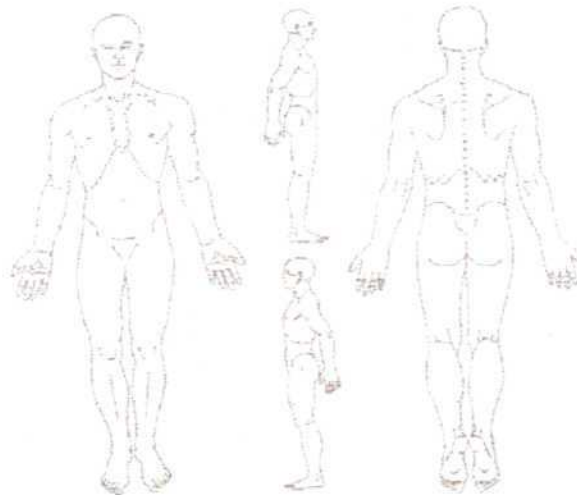
Moderate Manual Labor Heavy Manual Labor

General Physical Activity: No regular exercise Light exercise Strenuous exercise

How are your complaints affecting your ability to be otherwise active?

- No affect
- Some physical restrictions (able to perform light duty work & household tasks)
- Need limited assistance with common everyday tasks
- Need assistance often
- Have significant inability to function without assistance
- Am totally disabled (impaired) / Cannot care for myself

Mark an X on the picture below to indicate where you have pain &/or other symptoms, include symptoms of pain, numbness, &/or tingling.



I authorize The BackCenter & Associates to perform an examination & any & all treatment deemed necessary by them.

Patient's Signature _____ Date _____

WELCOME TO OUR OFFICE

We are committed to providing you the best care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Feel free to ask any questions you may have regarding our fees or your responsibility in complying with our financial policies/procedures.

- **Cash Patients:** Payment is due when services are rendered. We gladly accept Master Card, Visa, check, or cash.
- **Insurance Patients:** Please pay 20%, or your co-insurance %, for your first visit charges. Professional services are rendered and charged on your behalf. Any services not covered by your insurance are ultimately your responsibility and may have to be paid at the time of service. If you fail to keep your scheduled appointments or if you discontinue care for any reason other than doctor appointed discharge, the bill is due and payable by you in full, immediately, regardless of any insurance claims submitted. Our office accepts billing for Individual and Group policies, Personal Injury claims, and authorized Worker's Compensation.
- **Collection/Attorney Fees:** I agree to pay all costs of a collection agency if necessary to obtain payment if/when legal action occurs in order to collect an unpaid balance for medical services rendered. I agree to pay reasonable attorney's fees or other such costs as the court determines proper.
- **Authorization to Process Drafts:** I agree that The Back Center & Associates, LLC shall be appointed as my agent to endorse drafts on any checks for payment of my bill for medical services rendered.
- **Limited Release of Medical Information:** I authorize The Back Center & Associates, LLC to make inquiries and to release any pertinent information to any insurance company, adjuster, or attorney to facilitate collection under these assignments.
- **Assignment of Cause of Action:** In the event that any insurance company or third party obligated to make payment to me or to The Back Center & Associates, LLC for services rendered, refuses to make such payment upon demand, I hereby assign, transfer, and convey to The Back Center & Associates all cause of action that might exist in my favor against any such company or person. I authorize The Back Center & Associates to prosecute said action in my name or their name to collect fees due for care rendered and legal expenses, and to resolve said claims as they see fit.

Financial Arrangements: _____

Signature: _____

Date: _____

For Office Use Only:

Print Patient Name: _____

Account #: _____



THE BACK CENTER & ASSOCIATES, L.L.C.

APPOINTMENT CANCELLATION POLICY

Without exception, all massage/Soft Tissue Therapy appointments require a 24 hour notice of cancellation or change. Any cancellation after the required time, or those who do not show for their appointment will be charged \$30.00 for the missed appointment.

When you schedule a massage/Soft Tissue Therapy, this appointment is reserved specifically for you. If you miss your appointment, without providing proper notice, we are required to pay the therapist for the reserved appointment regardless of the circumstances.

Also, charges for missed appointments are not eligible for insurance reimbursement. Your health insurance company will not pay for missed or cancelled appointments thus the charges are solely your responsibility.

Thank you for understanding and cooperation regarding this policy. If you have any questions please feel free to ask us for more details before signing this form

****I have read this policy and I agree that if I am unable to keep a scheduled appointment, I will notify the office by telephone at (480)248-7231, at least 24 hours prior to my scheduled appointment in order to avoid the cancellation/no-show charge of \$30.00****

Patient Signature

Date