Date: _______
Last Visit: _______

Regional Chiropractic Center

Re-Examination Form

Name: ____________________________ **D.O.B:** __________ **Age:** _________
Address: ____
Email: __________________________________
Phone Number: ________________________

Has your insurance changed since your last visit? YES / NO
If circled yes, please provide the front desk with new card(s).

Have you had any surgeries since you were last seen? YES / NO

Type of Surgery	*Date of Procedure*

Have you had any type of accident since your last visit? YES / NO
(Work injury, Automobile, Falls, etc)

Type of Accident	*Date of Incident*

If your visit is in conjunction with an accident (automobile or workers comp.), please provide the front desk with insurance information. WE DO NOT BILL THIRD PARTY INSURANCE.

What is the primary reason for your visit today?

____

____

Patient Signature: ______________________________ **Date:** ____________

Parent/Guardian Signature: ________________________ **Date:** ___________

FEES ARE PAYABLE AT TIME OF SERVICE!

I hereby authorize Dr. Ladd or Dr. Bell and whomever designated as the assistant to administer treatment deemed necessary. I understand that Chiropractic does not diagnose or treat disease. Chiropractic has only one goal: To locate, analyze, and correct spinal interference to the nervous system. I verify all information provided is accurate and true.

I the undersigned,
*have insurance with (name of insurance)*_______________________________
and assign directly to Regional Chiropractic Center, INC. (Dr. Wayne Ladd or Dr. Christopher Bell) all benefits.

I hereby authorize the office to release all information necessary to secure payment of benefits. I authorize and use this signature on all insurance submissions whether manual or electronic.

I acknowledge that a copy of the financial policies has been offered to me and payment is due at the time of treatment, unless other arrangements have been made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of minors/children.

I accept full responsibility for ALL charges NOT covered by insurance. I understand that I am financially responsible for all charges, regardless of insurance payment.

I acknowledge that a copy of HIPAA privacy practices have been offered to me.

I hereby authorize Regional Chiropractic Center to furnish information to any referring institute/physician or insurance concerning my illness and treatment.

I have read the explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient Signature:

____ **Date:** ______________

Parent/Guardian Signature:

____ **Date:** ______________