HANKISON FAMILY CHIROPRACTIC & ACUPUNCTURE

Massage Therapy Questionnaire

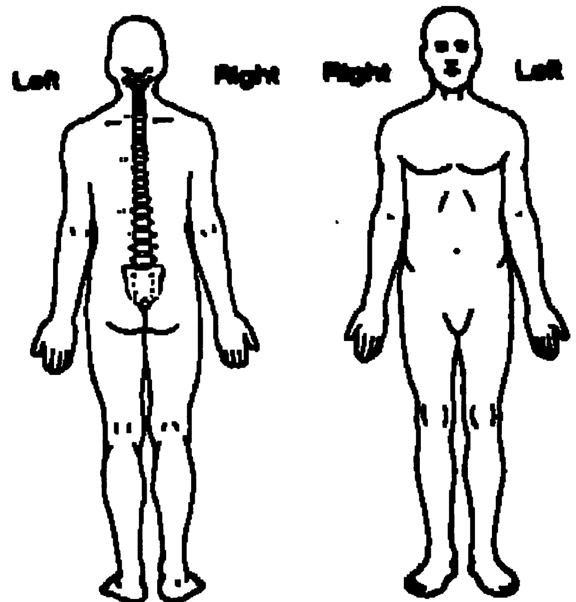
Patient / Client Name ____________________________ Social Security # ____________________
Current Address ____
Phone__________________
City ____________________ State ________________ Zip code_________
Employer ____________________________ Work Phone __________________
Date of Birth ___________________ Marital Status ______________

IN CASE OF EMERGENCY, CONTACT:
Name ____________________ Relationship _____________ Phone ______________

Reason for Visit ____
Is Condition due to an accident? __No __Yes -- Date: _____________
Type of accident: __Auto __ Work __Home __Other __________________
When did your symptoms appear? ____
Have you had this problem before? ________ If so, when? ______________________
Is this condition getting progressively worse? __Yes __No __Unknown

Type of pain: (check all that apply)
__Sharp __Dull __Throbbing __Aching
__Numbness __Shooting __Burning
__Tingling __Cramps __Stiffness __Other

Mark an X on the picture where you are having problems



How often do you have this pain? ______________
Is it constant or does it come and go? __________

Does it interfere with:
__Work __Sleep __Daily Routine __Recreation

Activities or movements that are painful:
__Sitting __Standing __Walking
__Bending __Lying Down

Have you tried anything (Ice, Heat, Medication) to improve your condition? ____________________

Did it help? ____________

Does anything make your problem worse? ________
If so, what? ___________________________

Have you found any position which relieves your problem? ___________________

What treatment have you already received for your condition?
__Medications __Surgery __Chiropractic Services __None __Other

Patient / Client Name ______________________________ Date ____________

Health History

Check any you have had in the past / Circle any which are ongoing

Headaches__ Dizziness__ Blurred Vision__ Concentration Loss__

Depression__ Nervousness__ Difficulty Sleeping__ Fainting__

Palpitation__ Neck Pain__ Shoulder Problems__ Back Pain__

Chest Pain__ Indigestion__ Stomach Problems__ Hypertension__

Heart Problems__ Bowel Problems__ Leg Pain/Cramps__ Circulatory Problems__

Other (describe)____

Are you pregnant? No__ Yes (due date) ______________________

Injuries/Surgeries you have had:	**Description**	**Date**
Head Injuries	______________________	__________
Broken Bones	______________________	__________
Dislocations	______________________	__________
Surgeries	______________________	__________

Family History: (For Example: Cancer / Diabetes / Heart Trouble / Emphysema / Back Problems)

Father: ____

Mother: ____

MEDICATIONS	**ALLERGIES**	**VITAMINS/HERBS/MINERALS**
______________________	__________	______________________________
______________________	__________	______________________________
______________________	__________	______________________________
______________________	__________	______________________________

Is there anything else that you feel the Massage Therapist should know before your massage?

Patient/Client Signature______________________________ Date____________________

Our Insurance & Financial Policy

We will gladly accept your insurance assignment in lieu of payment from you for your care and treatment in our office. The following policy prevails:

If your policy is verified and proven to cover chiropractic services, it is the policy of this office to accept assignment on part of your bill. This enables you to have less out-of-pocket expense. If it has not been verified, fees for services rendered are expected to be paid at the time of service.

HERE'S HOW IT WORKS!

1. You are responsible for your deductible **in full**.
2. Thereafter, on each visit, you pay that portion not covered by your insurance company. You may also choose to make one weekly payment for your convenience.
3. You also pay that portion of any re-examination, comparative x-rays, or additional procedures not covered by your insurance company.
4. We will collect the balance from your insurance company.

For those patients who do not have insurance coverage for our services, you may pay at the time of service by: MASTERCARD, VISA, PERSONAL CHECK or CASH. **All fees for services rendered are expected to be paid at the time of service unless prior financial arrangements have been made.** THERE IS A $25 SERVICE CHARGE FOR RETURNED CHECKS.

If your health problem is the result of an **automobile accident**, we will gladly bill all charges to your auto insurance after coverage has been verified. You must present all automobile insurance information at the time of your initial visit.

If your health problem is the result of a **work-related injury**, please let us know before you see the doctor. State law is specific on how we must bill our charges.

IF YOU HAVE ANY QUESTIONS CONCERNING OUR INSURANCE & FINANCIAL POLICY, PLEASE DO NOT HESITATE TO SPEAK TO US.

I have read and understand the above policy. I understand that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges. I further agree that should it be necessary for Hankison Family Chiropractic, Inc. to it's agents to employ collection and/or legal counsel, I hereby agree that I am responsible for collection charges incurred, which will be added to my bill.

_______________________________ ____________

Patient / Parent (Guardian) Signature Date

ASSIGNMENT OF BENEFITS:

I authorize and direct that payment be made directly to: Hankison Family Chiropractic, Inc. James F. Hankison, DC, or Heather R. Hankison, DC, 1455 S Ferdon Blvd Ste.D2, Crestview, FL, 32536 for any and all insurance benefits or reimbursement for services rendered by them which amounts would otherwise be payable to me under any insurance or pre-paid health care plan.

_______________________________ ____________

Patient/Parent (Guardian) Signature Date

RELEASE OF INFORMATION:

I authorize the release of any information concerning my health care services to my insurance companies, pre-paid health plan or Medicare/Medicaid.

_______________________________ ____________

Patient/Parent (Guardian) Signature Date