Welcome to Delp Chiropractic

Thank you for allowing us the opportunity to assist you with your concerns.

Where is the number one concern that brings you in today?

Does that discomfort radiate or move to another area?

(arm, leg, hand, or hip/buttock?) Certain side or area?

On a scale of 1-10. What number can your discomfort go up to?

1 is almost no discomfort and 10 is significant discomfort

How often do you notice any discomfort?

(Not considering the time when you are asleep.)

Constant 75% to 100%___ Frequent 51% to 75%____ Intermittent 26% to 50%____

Occasional 0% to 25%_____

When did you first notice this issue?

Days, weeks, months, years? _____

What is this concern keeping you from doing to enjoy your life?

Playing with kids or grandkids, work a full day comfortably, etc.

Patient Name_____ **DOB**_____

PATIENT INTRODUCTION FORM

Delp Chiropractic
954 N. Main St., Mt. Airy, NC 27030
336-786-5555

Name (Mr., Mrs., Ms.) _____ Date _____

Street Address _____ Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Cell Phone Carrier (For Appointment Reminders) _____

Social Security No. _____ Email Address _____

Age _____ Date of Birth ____/____/____ Married ____ Single _____ Other _____

Occupation _____ Employer _____

Office Address, City, State _____ Phone (office) _____

Primary Care Physician _____ Phone _____

Name of Insurance _____

Policyholder's Name _____ Policyholder's Phone# _____

Policyholder's Address _____

Policyholder's Employer _____ Policyholder's birthdate ____/____/____

Previous Chiropractic Care Yes _____ No _____ Doctor's Name _____

Nearest Relative or friend who may be called in case of emergency _____

Relationship _____ Phone _____

Who (or what source) referred you? _____

It is usual and customary to pay for services as rendered unless otherwise arranged.

To our valued patients: In order to keep the cost of your healthcare at a moderate price, Delp Chiropractic is a zero-balance facility. This means we do not bill our patient's or send monthly statements. Co-pay or Coinsurance is due on each visit.

Scheduling Appointments: Delp Chiropractic understands that sometimes circumstances prevent our patients from keeping their scheduled appointments. If you cannot keep your regularly scheduled appointment, please notify our office 24 hours in advance so that others in need can take our appointment slot. Also, if you are running more than 10 minutes late for your scheduled appointment, please notify our office. Thank you.

Patient's Signature X _____ **Date** _____

Release of Records

I, do hereby authorize Delp Chiropractic / Dr. Adam Delp to release my medical and billing records to any of its billing companies, attorneys, adjusters, insurance companies, etc. for the purpose of getting my bills paid.

X_____ ____/____/_____

Permission to Collect on Insurance Checks

I expressly authorize and give permission to Delp Chiropractic / Dr. Adam Delp, and their billing agents, for the signing and completing of any form in the completion of my claims and endorsing any check made payable to me, in support of processing or making payment of claim for any charges incurred by me at these offices. Further, these offices acknowledge that it is only entitled to receive payment for only those charges which were incurred through their office and any overpayment will be refunded appropriately and timely.

X_____ ____/____/_____

Notice of Privacy Practices

I acknowledge that I understand that Delp Chiropractic cannot release my information without proper permission from me and that they will make available a copy of the Privacy Act for my records if I do so request.

X_____ ____/____/_____

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible : _____(minor) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by Dr. Delp and/or other licensed Physicians of Chiropractic who may treat me now or in the future at his office. I have had an opportunity to discuss with Dr. Delp and /or with other office or clinic personnel in the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including but not limited to, fractures, disc injuries, strokes (CVA), dislocations and sprains, I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedures which the physician feels are in my best interest at the time, based upon the facts then known.

I have read, or have had read to time, the above consent. I have also had an opportunity to ask questions about its contents and by signing below, I agree to the treatment recommended by my physician(s) and for any condition(s) for which I seek treatment at this facility.

Print Name X_____ **Sign Name X**_____

Consent for Treatment for Minors

I hereby authorize Dr. Adam Delp (and whomever he may designate as his assistant(s) to administer chiropractic care as he deems necessary to my child named _____.

Guardian's signature_____ ____/____/_____

Witness:_____ Signature:_____ Date: ___/___/_____

AUTHORIZATION TO RELEASE INFORMATION

Patient _____

Address _____

Date of Birth _____

I authorize any medical, osteopathic, or chiropractic physician, hospital, clinic, rehabilitation facility, or other medical practitioner or provider who has or is or will be furnishing services to me to provide my medical information, including history, treatment, diagnosis and prognosis to Delp Chiropractic.

This ____day of _____, 20___

X_____

Patient Signature