



**Welcome to  
Better Bodies Chiropractic and Wellness**

**Personal Information**

Full Legal Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
*First MI Last*

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP + 4: \_\_\_\_\_ SSN: \_\_\_\_\_

Male / Female (*Circle One*) Status (*circle one*): Single / Married / Widowed / Divorced / Legally Separated / Minor

Primary Language (e.g. English / Spanish): \_\_\_\_\_ Ethnicity (*circle one*): Hispanic or Latino / Not Hispanic or Latino

Race (*circle one*): American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander / White

Date of Birth : \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ ext \_\_\_\_\_

May we text appointment reminders to you? (*circle one*) Yes / No If Yes, who is your cell carrier? \_\_\_\_\_

When we need to call you, what are your Primary and Secondary Phone Preferences (e.g. home, cell, etc.)? 1) \_\_\_\_\_ 2) \_\_\_\_\_

Overall, how do you prefer that we contact you? If Phone, please note which phone. (Text is an option.) \_\_\_\_\_

Email Address: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Do you have children? (*circle one*) Yes / No If Yes, how many? \_\_\_\_\_

Current Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_ Do you smoke? (*circle one*) Yes / No / Former Smoker

Do you currently take prescription medication for high blood pressure? (*circle one*) Yes / No

**Emergency Contact**

Name \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Who is your Medical Doctor (PCP)? \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_

\_\_\_\_\_ (Initials) By initialing here, I authorize Better Bodies Chiropractic to send my Medical Doctor (PCP) a report of findings from my evaluation at its facility.

PLEASE CONTINUE TO NEXT PAGE.

**Insurance Information** (If you have insurance, we must copy your current card and photo ID.)

Insurance Company: \_\_\_\_\_ Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of Insured (if NOT you): \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Insured's DOB (if NOT you): \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

Is this a workman's comp case? Y / N

If yes, who is your case manager?: \_\_\_\_\_ Telephone number: \_\_\_\_\_

\_\_\_\_\_ (Initials) I fully understand that I am solely responsible for any balance not paid by the insurance company. Co-payment or coinsurance is due at time of service.

OR

\_\_\_\_\_ (Initials) I have no chiropractic insurance coverage and fully understand that I am solely responsible for the balance in full at time of service.

**Electric Stimulator**

\_\_\_\_\_ (Initials) I fully understand that electrotherapy (aka estim) can be an extra \$10.00.

**Reason for Visit**

The reason for this visit is the result of (circle one): Work / Sports / Auto / Trauma / Chronic

Explain what happened: \_\_\_\_\_

When did this condition begin? \_\_\_\_\_

Is this condition getting worse (circle one)? Yes / No / Constant / Comes and Goes

Is this condition interfering with your (circle one) Work / Sleep / Daily Routine / None

If Yes, please explain:

\_\_\_\_\_

Have you been treated by a Medical Physician for this condition (circle one)? Yes / No

If Yes, by whom or where were you treated?

\_\_\_\_\_

Have you ever been treated by a chiropractor (circle one)? Yes / No

If Yes, by whom? \_\_\_\_\_

If Yes, when were you last treated? \_\_\_\_\_

Is there anything else you feel we should know? \_\_\_\_\_

# Health History

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

## CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- |  |  |   |                                      |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Mumps         | <input type="checkbox"/> Influenza        |                                      |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox     | <input type="checkbox"/> Pleurisy         | <b>INTAKE</b>                        |
| <input type="checkbox"/> Polio           | <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Arthritis        | <input type="checkbox"/> White Sugar |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Coffee      |
| <input type="checkbox"/> Whooping Cough  | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tea         |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago          | <input type="checkbox"/> Alcohol     |
| <input type="checkbox"/> Measles         | <input type="checkbox"/> Thyroid       | <input type="checkbox"/> Eczema           | <input type="checkbox"/> Cigarettes  |

Have you been tested HIV positive? Yes  No

## CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS, NOT INCLUDING YOUR PRESENTING COMPLAINT (the reason you are here today).

### MUSCULO-SKELETAL

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

### GASTROINTESTINAL

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids

### FEMALES ONLY

When was your last period? \_\_\_\_\_  
 Are you pregnant? Yes  No  Maybe

### NERVOUS SYSTEM

- Nervous
- Numbness
- Paralysis
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling
- Extremities
- Stress
- Dizziness

- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

### GENTO-URINARY

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

### FAMILY HISTORY

The following members have a same or similar condition as I do:

- |                                  |                                 |
|----------------------------------|---------------------------------|
| <input type="checkbox"/> Mother  | <input type="checkbox"/> Father |
| <input type="checkbox"/> Brother | <input type="checkbox"/> Sister |
| <input type="checkbox"/> Spouse  | <input type="checkbox"/> Child  |

### GENERAL

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

### C-V-R

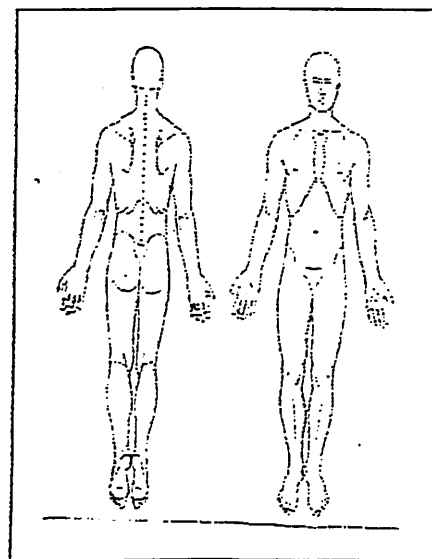
- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

### MALE/FEMALE

- Menstrual Cramps
- Menstrual Irregularity
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems \_\_\_\_\_

### EENT

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose



Please outline on the diagram the area of your discomfort.

## Health History Continued

Please list any other serious medical condition(s) you have or ever had: \_\_\_\_\_

Please list anything to which you may be allergic: \_\_\_\_\_

List previous surgeries/treatments with dates: \_\_\_\_\_

List any past serious accidents with dates: \_\_\_\_\_

Are you taking any of the following medications?  Nerve Pills  Pain Killers (including aspirin)  
 Muscle Relaxers  Stimulants  Blood Thinners  Tranquilizers  Insulin  
 Other (s) \_\_\_\_\_

Do you: Take Supplements or Vitamins?  Yes  No      Exercise?  Yes  No

Are you wearing:  Heel Lifts  Sole Lifts  Inner Soles  Arch Supports

### Please Read and Sign

\*We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

\*I authorize the staff to perform any necessary services needed during diagnosis and treatment. I authorize the provider and or managed care organization to release any information required to process insurance claims.

\*I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company (if offered at this office).

\*Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collections agency fees, and any other expenses incurred in collecting your account.

\*I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any further changes to the information I have provided.

Signature \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Adult Patient     Parent or Guardian     Spouse

Better Bodies Chiropractic, PC  
Chiropractic, Physical Therapy and Massage  
Drs. Jeffrey and Ginger Foddrell  
1570 Early Settlers Rd.  
N. Chesterfield, VA 23235

Standard Authorization Of Use And Disclosure Of  
Protected Health Information

Information to be used or disclosed:

The information covered by this authorization includes: Your name, accumulated health records, examination scans and x-rays, and any information in your patient file or travel card.

Persons authorized to use or disclose information:

Better Bodies Chiropractic and current employees of Better Bodies Chiropractic.

Persons to whom information may be disclosed:

Office employees at minimal degree when deemed necessary, your private physician, hospitals, attorneys if authorized or subpoenaed, referral and welcome boards in our office, birthday and holiday cards, referral; and thank you letters, testimonial book (including your picture if authorized), insurance carriers, any outside collection services retained by Better Bodies Chiropractic (electronic claims service).

Expiration date of authorization:

This authorization is effective as of your signature date and is ongoing until you revoke or terminate this authorization by submitting a written revocation to Better Bodies Chiropractic.

Potential for re-disclosure:

Information that is disclosed under this authorization may be disclosed again by the person or organization, which revoked or terminated initial authorization. Re-disclosure must be in writing.

Name of Patient: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of patient representative: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship of patient representative to patient: \_\_\_\_\_

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Release of Protected Health Information

I give permission to Better Bodies Chiropractic to discuss medical information, release test/x-ray results, appointment/times, and payment issues to the following people:

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*\*This notice will remain in effect until notified in writing by the above patient.*





## Office Policies

We believe that a clear definition of our office policy will allow both you, the patient; and us, Better Bodies Physical Therapy, to concentrate on the bog issues — regaining and maintaining your health.

### Appointments

Multiple appointments are arranged for convenience to all patients. Should it be impossible to keep an appointment, we do expect notice as soon as possible. Regardless of how many appointments ore scheduled for you each week, please keep in mind that it is the frequency of your visits and not the days that are important. If you are unable to keep your appointment for any reason, please call immediately to reschedule your visit.

If you miss an appointment, you may be assessed a \$45 missed appointment fee.

If you are late for your appointment, your appointment may need to be rescheduled or services may need to be reduced (example: reduced therapy time)

### Financial Policy

All fees are dependent upon services rendered and are ultimately the responsibility pr the patient regardless of whether or not this office accepts insurance assignment for payment of bills. If your insurance is qualified by our insurance coordinator you may be extended the courtesy of assigning insurance benefits directly to the office by thereby reducing your out of pocket expenses.

All durable medical supplies are payable by the patient when supplies are received.

Any balance past due 90 days will be sent to our collection agency and all costs of collection, including attorney's fees, equal to 1/3 of all sums due and payable will be added to your account. Also we will assess a FINANCE CHARGE equal to 1% per month (18% annual) on the amount you owe at the beginning of the billing cycle, less than any payments and credits received during the billing cycle.

It is the goal of this office to provide you with the finest quality Physical Therapy available. If you have any questions with regard to your healthcare or any of our office policies, please let us know, we welcome your referrals and look forward to a doctor-patient relationship that works for our mutual benefit.

By signing I acknowledge that I have read the preceding information and understand my responsibilities and those of the office.

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Printed name of Patient or Legal Guardian

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Patient Signature

Date





## **Insurance Assignments**

It is the policy of this office to extend to our patients the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out of pocket expense.

- 1) Our office will qualify your insurance coverage in an effort to help you determine exactly what chiropractic coverage is available to you under your policy and if it will be accepted as payment toward your bill.
- 2) For your initial visit, all deductible payments must be made prior to insurance submittal.
- 3) Deductibles, co-payments and payment plan amounts are expected at the time of service or at the beginning or end of each week.
- 4) From time to time we may experience difficulty in collecting from your insurance company and since insurance assignment is a courtesy, it may be terminated at any time. We will, of course, give you ample notice and ask that you act in your own behalf with your insurance company.
- 5) **This office does not promise that your insurance company will pay for the usual and customary charges of this office, nor will this office enter into a dispute with an insurance company over reimbursement. We cannot alter or guarantee your insurance company.**
- 6) Should you receive payment from the insurance company as a result of insurance forms summated from this office, you will promptly submit such payments to this office within a week to cover any outstanding balance on your account.
- 7) Should your insurance reflect, dispute or not cover the total amounts of charges submitted, YOU will pay any outstanding balance within 30 days of verbal or written notification. It will be your responsibility to pursue reimbursement from the insurance company.
- 8) It is understood and agreed that you, the patient, are responsible for perfecting and following up on any insurance claims. If your account is turned over to an outside party for collection, the undersigned agrees to pay all cost of collection, including attorney's fees, equal to 1/3 of all sums due and payable. If the unpaid balance of your accounts not paid in full within 90 days of the date shown on your monthly statement, we will assess a finance charge equal to 1% per month (18% annual) on the amount you owe at the beginning of the billing-cycle, less any payments and credits received during the billing cycle.

I have read the preceding information and understand my responsibilities and those of the office. I hereby assign any and all insurance benefits to Better Bodies Physical Chiropractic and authorize Better Bodies Physical Chiropractic to act as agent in helping obtain payment from the indicated insurance companies.

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Printed name of Patient or Legal Guardian

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Patient Signature

---

Date

# PATIENTS' RIGHTS AND RESPONSIBILITIES

## STATEMENT OF RIGHTS

- Patients have the right to be treated with dignity and respect.
- Patients have the right to fair treatment regardless of race, religion, gender, ethnicity, age, disability or source of payment.
- Patients have the right to have their treatment and other information kept private.
- Only in life-threatening situations or if required, can records be released without a signed consent from patients.
- Patients have the right to information from staff/providers in a language they can understand.
- Patients have the right to an easy-to-understand explanation of their condition and treatment.
- Patients have the right to know all about their treatment choices regardless of cost coverage.
- Patients have the right to get information about services offered by their providers and patient role in the treatment process.
- Patients have the right to know the clinical guidelines used in providing and/or managing their care.
- Patients have the right to provide suggestions on office policies and procedures.
- Patients have the right to complain and to know about the complaint, grievance and appeals process.
- Patients have the right to know about State and Federal laws governing their rights and responsibilities.
- Patients have the right to participate in the formation of their plan of care.

## STATEMENT OF RESPONSIBILITIES

- Patients are responsible for providing their medical provider with information needed to deliver quality care.
- Patients are responsible for informing their provider when/if their treatment plan is no longer effective.
- Patients are responsible to follow their treatment plans and to inform their provider of any changes to the treatment plan made by other providers including any changes in their medications.
- Patients are responsible for reviewing their care and treatment plans continuously and reporting effectiveness or ineffectiveness of the care plan to their provider.
- Patients are responsible for treating those giving them care with dignity and respect.
- Patients should not be involved in any conscious behavior that could harm the lives of their provider, office staff or other patients.
- Patients are responsible for keeping their appointments, arriving on time and notifying the office of any cancellations at least 24 hours prior to the appointment.
- Patients are responsible for addressing questions about their care to their provider and ensure understanding of their care and their role in the treatment process.
- Patients are responsible for notifying their provider of any concerns regarding payment or insurance coverages.