New Patient Intake Form

Name/Nombre: _____
Last name/Apellido First/Nombre

Address/Direccion: _____ Apt.#: _____

City/Ciudad: _____ State/Estado: _____ Zip: _____

Email: _____ Cell#: _____

DOB/Fecha de nacimiento: _____/_____/_____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

SS#: _____ ☐ Female ☐ Male

Whom may we notify in an emergency? _____ **Relationship**_____
Tel.#: _____

INJURY

Please describe where you are having pain/Por favor describa donde siente dolor:

_____

_____

Have you lost any days of work? ☐ Yes ☐ No If so, when:_____

List any other Doctors seen for this injury: _____

Please list medication(s) presently taking: _____

HEALTH HISTORY

List Previous surgeries/disease with dates: _____

Allergies to any medication? ☐ Yes ☐ No _____

Past Illnesses? _____

Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No If yes, who? _____

Have you been treated for any health condition by a physician in the last year? _____

Are you pregnant? ☐ Yes ☐ No If yes, how far along? _____

Check **(X)** conditions/symptoms you have or have had.

- ☐ Difficulty sleeping
- ☐ Diarrhea
- ☐ Constipation
- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficult chewing
- ☐ Difficult swallowing
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting food
- ☐ Abdominal Pain
- ☐ Arthritis
- ☐ Asthma
- ☐ Herniated disk
- ☐ Pacemaker
- ☐ Fractures
- ☐ Tiredness
- ☐ Headache
- ☐ Dizziness
- ☐ Fainting
- ☐ Blurred vision
- ☐ Ear Pain
- ☐ Hearing loss
- ☐ Chest pain
- ☐ Pain over heart
- ☐ Difficult breathing
- ☐ Persistent cough
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ High cholesterol
- ☐ Lung problems
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Tumors
- ☐ Cancer
- ☐ Diabetes
- ☐ Bronchitis
- ☐ Ulcers
- ☐ Aids/HIV
- ☐ Breast lump
- ☐ Bleeding disorders
- ☐ Heart disease

INSURANCE INFORMATION

Please provide **your insurance** information

Name of insurance: _____ Phone#: _____

Insured's name: _____ Relationship: _____

AGREEMENT

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. Should it be necessary to take action to collect any amount owing under this agreement. I will be responsible for all attorney, collection fees, and any other costs incurred in collecting the amount owed.

X _____ _____

Patient Signature (Parent/Guardian if minor) **Date**

CONFIDENTIAL HEALTH INFORMATION
INFORMACION MEDICA CONFIDENCIAL

1. **The symptom(s) that have prompted me to seek care today include:**
   Los sintomas por los cuales se esta chequeando incluyen:

   _____

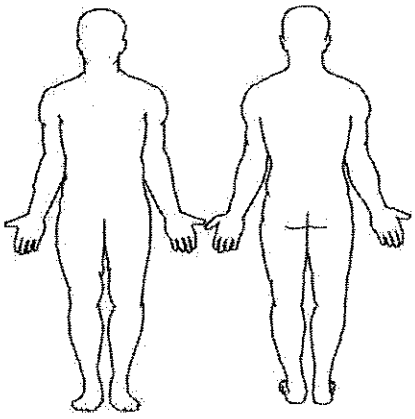
2. **And are the result of:** ☐ Auto accident ☐ Wellness care ☐ Work Injury
   Son el resultado de: Accidente de Auto Cuidado personal Lesion en el trabajo

   ☐ Worsening long-term problem ☐ Other _____
   Empeora con el paso del tiempo Otro

3. **Onset** (When did you first notice your current symptoms?): _____
   Inicio (Cuando noto por primera vez los sintomas actuales?):

Pain Location **Localidad del dolor**	**←Slight – Intensity – Severe →** **Leve Inetermedio Severo** (Circle below)	**Sensation/ Sensacion:** (numbness, tingling, stiffness, dull, aching, nagging, sharp, burning, shooting, throbbing, stabbing, etc.)
	1 2 3 4 5 6 7 8 9 10	
	1 2 3 4 5 6 7 8 9 10	
	1 2 3 4 5 6 7 8 9 10	
	1 2 3 4 5 6 7 8 9 10	
	1 2 3 4 5 6 7 8 9 10	
	1 2 3 4 5 6 7 8 9 10	
	1 2 3 4 5 6 7 8 9 10	
	1 2 3 4 5 6 7 8 9 10	
	1 2 3 4 5 6 7 8 9 10	
	1 2 3 4 5 6 7 8 9 10	
	1 2 3 4 5 6 7 8 9 10	

4. Mark (x) on the picture where you currently feel pain, En que lugar siente dolor?



5. Progression/ Progreso

Pain is getting □ Worse □ Better □ Same
El dolor siente Peor Mejor Igual

6. Duration and Timing/ Duracion

□ Constant □ Comes and goes
Constante Va y viene

How often/ Que tan seguido?

_____

7. Aggravating Factors (what makes it worse/ que le hace sentirse peor? Such as movements Movimientos, certain activities/ algunas actividades, time of day/momento del dia, etc.)

_____

_____

8. Relieving Factors (what makes it better/ que le ayuda a sentirse mejor?

_____

_____

9. Prior Interventions / Intervenciones Previas:
What have you done to relieve the symptoms?
Que ha intentado hacer para aliviar las molestias?

__ Prescription medication/Prescripcion medica

__ Surgery/ Cirugia

__ Over-the-counter drugs/ Medicinas

__ Acupuncture / Acupuntura

__ Physical Therapy Terapia Fisica

__ Massage

__ Ice

__ Heat

__ Chiropractic

__ Other: _____

Signature: _____ **Date:** _____

QUADRUPLE VISUAL ANALOGUE SCALE

INSTRUCTIONS: Please circle the number that best describes the question being asked.
INSTRUCCIONES: Por favor encierre el numero que mejor describa la pregunta.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint.
NOTA: Si ud. Tiene mas de una molestia por favor responda cada pregunta por cada molestia individualmente e indique el valor para cada uno.

EXAMPLE/ EJEMPLO:

Headache/Cabeza Neck/Cuello Low Back/ Espalda baja

0 1 (2) 3 (4) 5 6 7 8 (9) 10

1. What is your pain RIGHT NOW / Cual es su dolor EN ESTE MOMENTO?

0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain / Cual es su dolor TIPICO o PROMEDIO?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)
   Cual es el nivel de dolor CUANDO SE SIENTE MEJOR (Que tan cerca de 0 llega cuando esta mas aliviado?

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best? _____%
Que porcentaje en horas en la manana es su mejor estado de dolor?

4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?
   Cual es el nivel de dolor EN EL PEOR MOMENTO (que tan cerca de "10" es su dolor cuando es el peor)

0 1 2 3 4 5 6 7 8 9 10

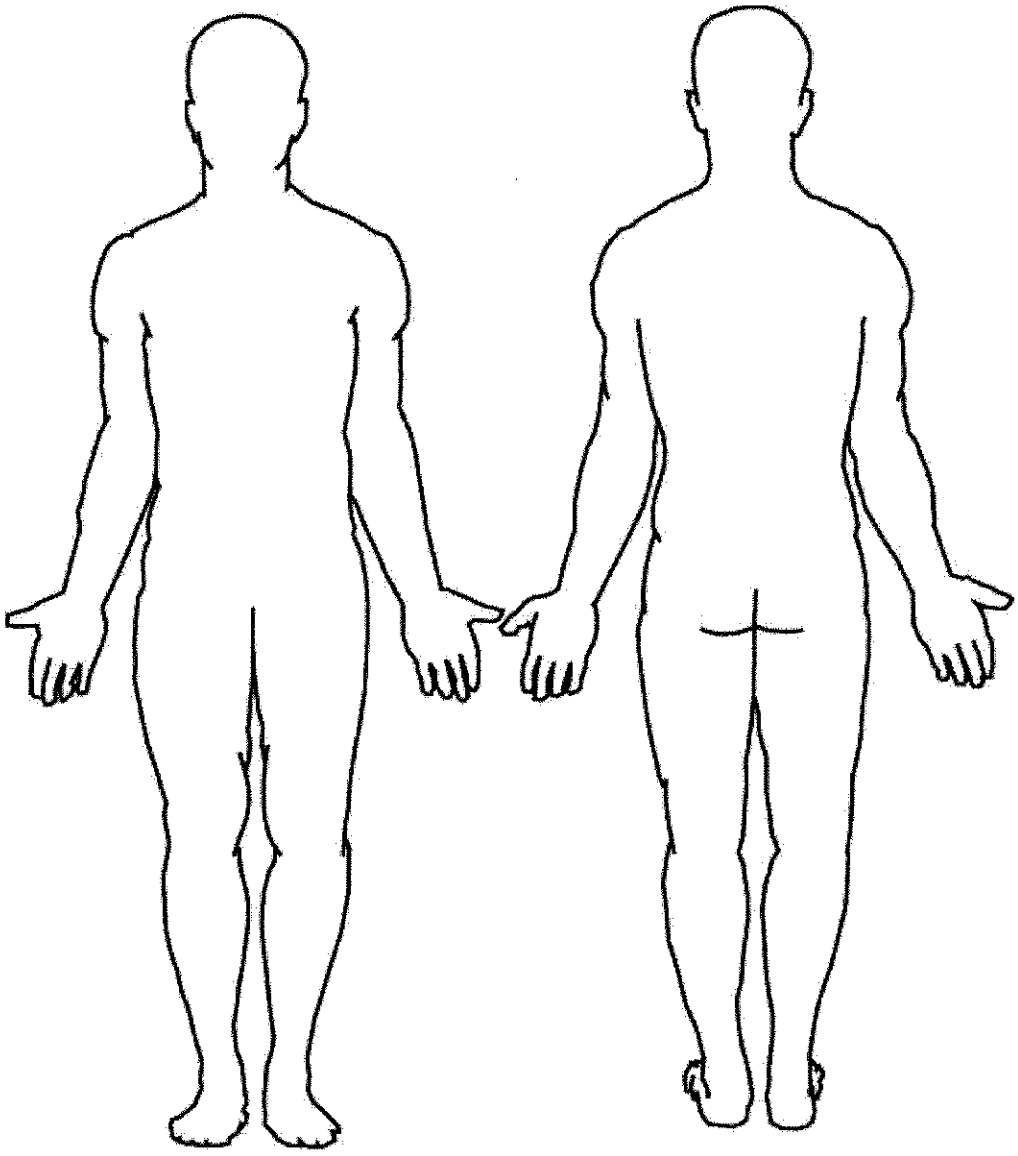
What percentage of your awake hours is your pain at its worst? _____%
Que porcentaje es en las horas de la manana su peor dolor?

Name: _____ **Account:** _____ **Date:** _____

FRONT/FRENTE

Mark an (x) on the diagram where you feel pain
Marque una (x) donde usted siente el dolor

BACK/ ESPALDA



What does the pain feel like? ☐ Stiffness ☐ Tingling ☐ Aching
☐ Burning ☐ Numbness ☐ Stabbing

Como se siente el dolor? ☐ Endurecimiento ☐ Adolorido ☐ Endormecido
☐ Cosquilleo ☐ Ardor ☐ Punzando

PHYSICAL MEDICINE AND REHABILITATION SERVICES

97010 Application of a modality to one or more areas; Hot or Cold Packs: The application of heat, through the use of hot packs, also called hydrocollator packs, is often most effective in sub-acute or chronic problems. The use of hot packs is considered a superficial heat application. In general terms, the application of cold (withdrawal of thermal energy) is the treatment of choice in a patient with acute trauma or severe plasticity. This application can be in the form of ice packs; in some applications, this is also referred to as "cryotherapy"

97012 Traction; Mechanical: The force used to create a degree of tension of soft tissues and/ or to allow for separation between join surfaces. The degree of traction is controlled through the amount of force (pounds) allowed, duration (time), and angle of pull (degrees) using mechanical means.

97014 IFC (Interferential Current/Medium Current): These units have a special carrier frequency that allows the current to go deeper into the tissues. IFC is used to control swelling and pain.

97035. Ultrasound: The use of sound waves to increase absorption of heat to a deeper penetration level. Much of the value of ultrasound is providing pain relief due to its superior depth of penetration. This modality is used in the treatment of arthritis, neuromas, and adhesive scars, and where increasing the temperature is the desired effect.

97110 Therapeutic Exercise: One or More Areas; Therapeutic Exercises to Develop Strength. and Endurance, Range of Motion, and Flexibility. Therapeutic Exercise incorporates one parameter (strength, endurance, range of motion, of flexibility) to one or more areas of the body. Examples include Kinetic Exercises (for range of motion), Lumbar stabilization exercises (flexibility), and gymnastic ball stretching/strengthening.

97140 Manual Therapy techniques: (e.g. mobilization/manipulation, manual lymphatic drainage, manual traction, myofascial release therapy)

Chiropractic Manipulative Treatment (CMT):
98940 Spinal, One to Two regions
98941 Spinal, Three to four or more regions
98943 Extraspinal, One or More regions (e.g. shoulder/knee)

By signing my name below, I acknowledge that I have read the above, had the opportunity to ask questions and that all my questions have been answered fully and satisfactorily. I have also received a copy of this form.

Print Name: _____
Signature: _____ **Date:** _____

I hereby authorize _____ (Insurance Company) to make payments directly to:

Ashburn Chiropractic & Rehab
44121 Harry Byrd Hwy Suite 125
Ashburn V.A 20147
Tel: 703) 723-0000 Fax: 703) 723-0058

The expense benefits allowable, and otherwise payable to me under my current insurance policy, toward the total charges for professional services rendered by the clinic.

I authorize this clinic to release any information, pertinent to my case/injury to any insurance company, adjustor, and attorney involved in this case. I hereby release this clinic of any consequence thereof.

I understand that I am financially responsible for all charges insured at this clinic including any and all deductibles, co-payments and co-insurance. Should it be necessary to take legal action to collect any amount owing under the agreement. I will be responsible for all attorneys, collection fees, and any other costs incurred in collecting the owed.

Print Name: _____ **Date:** _____

Patient Signature/Guardian: _____

Note: Parents or guardians must sign for minor

Patient Pregnancy Disclaimer

This certifies that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction. I understand the clinical necessity of having x-rays taken at this time and grant permission for this procedure. In doing so, I release the doctor/clinic from responsibility for potential damage arising from this procedure.

At the present time:

□ I am sure I am not pregnant

□ It's possible that I could be pregnant

□ I am pregnant

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such case, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specifically adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustment.

I, _____ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office gave been answered to my complete satisfaction.

I, therefore, accept chiropractic care on this basis.

_____ _____

(Signature) **(Date)**

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release: This is to certify that to the best of my knowledge I am not pregnant, and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that X-rays can be hazardous to an unborn child. **Date of last menstrual period:** _____

_____ _____

(Signature) **(Date)**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY. The Practice (the "practice"), in accordance with the Federal Privacy Rule, 45 CFR parts 160 and 164 (the "Privacy Rule") and applicable state laws, is committed to maintaining the privacy of your protected health information ("PH"I, PHI) Includes information about your health condition and the care treatment you received from the Practice and is often referred to as your health care of medical record. This notice explains how your PHI may be used and disclosed to third parties. This notice also details your rights regarding your PHI.

HOW THE PRACTICE MAY BE USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Practice, In accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purposes of: (a) Treatment- To provide you with the health care you require, the Practice may use and disclose your PHI to those health care professionals, whether on the Practice's staff or not, so that it may provide, coordinate, plan and manage your health care. For example, a chiropractor treating you for lower back pain may need to know and obtain the results of your latest physician examination or last treatment plan. (b)Payment- To get paid for services provided to you, the Practice may provide your PHI, directly or through a billing service, to a third party who may be responsible for your care, including Insurance companies and health plans. If necessary, the Practice may use your PHI in other collection efforts will respect to all persons who may be liable to the Practice for bills related to your care. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment time. (c) Health Care Operations- To operate in accordance will applicable law and Insurance requirements, and to provide quality and efficient care, the Practice may need to compile, use and disclose your PHI. For example, the Practice may use your PHI to evaluate the performance of the Practice's personnel in providing care to you.

Other EXAMPLES OF HOW THE PRACTICE MAY USE YOUR PHI: (a) Advice of Appointment and Services from time to time, contact you to provide appointment reminders. The following appointment reminders may be used: a) a postcard mailed to you at the address provided by you; and b) telephoning your home/leaving a message on your answering machine or with who answers the phone. (b) Directory/Sign-In Log- we maintain a sign-in log at its reception desk for individuals seeking care and treatment in the office. The sign-in log is located in a position where staff can readily see who is seeking care in the office, as well as the Individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices. (c) Family/Friends - The practice may disclose to a familiar member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care. We may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply: I) If you are present at or prior to the use or disclosure of your PHI; the practice may use or disclose your PHI if you agree, or if the practice can reasonably infer from the circumstances, based on the exercises of its professional judgment, that you do not object to the use or disclosure. (II) If you are not present, the practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interest and if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

OTHER USE & DISCLOSURES WHICH MAY BE PERMITED OR REQUIRED BY LAW

The Practice may also use and disclose your PHI without your consent or authorization in the following instances: (a)De-Identified Information- health information that may be related to your care but does not identify you and cannot be used to identify you. (b)Business Associate- The Practice may use and disclose PHI to one or more of its business associates if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payments to insurance information. Personal Representative- to a person who, under applicable law, has the authority to represent you in making decisions related to your health care. d) Emergency Situations for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible. The Practice may also use and disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation. e) Public Health Activities- when required by law to provide information to a public health authority to prevent or control disease. f) Abuse, Neglect or Domestic Violence- when authorized by law to provide information if it believes that the disclosure is necessary to prevent serious harm. g) Health Oversight Activities- We may use and disclose PHI when required by law to provide info in criminal investigations, disciplinary actions, or other activities relating to the community's health care system h) Judicial and Administrative Proceeding- in response to a court order or a lawfully issued subpoena. i)Law Enforcement Purposes- when authorized, to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena, or if the Practice believes that your death was the result of criminal conduct. i) Coroner or Medical Examiner- to a coroner or medical examiner for the purpose of identifying you or determining your cause of death. k) Organ, Eye or Tissue Donation-The Practice may use and disclose PHI if you are an organ donor to the entity to whom you have agreed to donate your organs. I) Research- The Practice may use and disclose PHI subject to applicable legal requirements if the Practice is involved in research activities. m) Avert a Threat to Health or Safety- The Practice may use and disclose PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat. n) Specialized Government Functions - when authorized by law with regard to certain military and veteran activity. o) Workers' Compensation - The Practice may use and disclose PHI if you are involved in a Workers' Compensation claim to an individual or entity that is part of the Workers' Compensation system. p) National Security and Intelligence Activities to authorized governmental officials with necessary intelligence information for national security activities. g) Military and Veterans- if you are a member of the armed forces, as required by the military command authorities. Authorization Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS

You have the right to: (a) Revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer (b) Request special restrictions on certain uses and disclosures of your PHI as authorized by law. In general, this relates to your right to request special restrictions concerning disclosures of your PI regarding uses for treatment, payment and operational purposes under Privacy Rule, Section 164.522 (a) and restrictions related to disclosures to your family and other individuals involved in your care under Privacy Rule, Section 164.510. (b) Except in certain instances, the Practice may not be obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment. (c) Receive confidential communications or PHI by alternative means or at alternative locations as provided by Privacy Rule Section 164.522(b). For instance, you may request all written communications to you marked "Confidential Protected Health Information." You must make your request in writing to the Practice's Privacy Office. The Practice will accommodate all reasonable requests. (d) Inspect and copy your PHI as provided by federal law (including Privacy Rule, Section 164.524) and state law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the dental reviewed as set forth more fully in the written denial notice. (e)Amend your PHI as provided by federal law (including Privacy Rule, Section 164.526) and state law. To request an > amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reas9n that supports your request. The Practice may deny your request if it not in writing. If you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement (f)Receive an accounting of disclosures of your PHI as provided by federal law (Including Privacy Rule Section 164.528) and state law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period, which may not be a longer than six (6) years and may not include. dates before April 14, 2013. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free, but the Practice may charge you for the cost of providing additional lists. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred. (g)Received a paper copy of this Privacy Notice from the Practice (as provided by Privacy Rule Section 164.520(b)(1)(1v)(F)) upon request to the Practice's Privacy Officer. (h)Complain to the Practice or to the Secretary of HHS (as provided by Privacy Rule Section 164.520(b)(1)(vi)) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions you want answered about your privacy rights (as provided by Privacy Rule Section 164.520(b)(2)(vii)), you may contact the Practice's Privacy Officer as follows: Name: Mohammad Yousefi at 9200 Colesville Road Silver Spring, MD 20910 Phone#:_301-585-3200

PRACTICE'S REQUIREMENTS

(a)Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI. (b)Under the Privacy Rule, may be required by State Law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law. (c)The -Practice is required to abide by the terms of this Privacy Notice (d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all your PHI that ii maintains. (e)Will distribute any revised Privacy Notice to your prior to implementation (f)Will not retaliate against you for filling a complaint. Effective Date This Notice is in effect as of 04/15/2013.

PATIENT ACKNOWLEDGEMENT By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

_____

Print Name

_____ _____

Signature Patient/Guardian **Date**

Ashburn
Chiropractic & Rehab

Date

Dear Patient:

In behalf of Ashburn Chiropractic and Rehab Center, we are extremely thankful that you have chosen us for your treatment,

Due a continuing rising cost, and Insurance companies not covering some of the treatment procedures, Ashburn Chiropractic has worked diligently to overcome cost increases such as these through our continuous improvement in our treatments, however we cannot absorb the impact of this costs no-covered by Insurances companies and we have come with packages for the special treatments effective immediately.

Dry Needling and Cupping Packages:

- **Per visit $25 (duration 15 min)**
- **5 Visits $100 ($20 per visit) Save $25**
- **10 visit $150 ($15 per visit) Save $100**

Thank you for you business and your understanding on this matter, if you have any questions please let us know.

Sincerely,

Ashburn Chiropractic and Rehab

Patient Signature/ Date

44121 Harry Byrd Hwy- Suite 125- Ashburn, VA 20147- Tel: 703.723.0000- Fax: 703.723.0058
Email: myashburnchiro@yahoo.com - www.ashburnchiropractiandrehab.com

Dear patients of Ashburn Chiropractic and Rehab Center:

1.) Please Note the following Amendments to our Office Policies, effective January 01, 2022.

Please Note that as of **January 01, 2022** we are **Amending** and **Implementing** a new **$55.00 Fee** for **Missed** or **Cancelled** appointments **without a prior 24-hour notice to our Office.**

Patients will be billed accordingly for any Missed or Cancelled appointments.

If you would like us to keep your card on file, please check: **Yes**____ **No**____

If yes, please give the front desk your card information.

2.) All patients will be asked as of January 01, 2022 for both their **Drivers License** and **Insurance Cards as** patient's addresses and or Insurance/Benefits may have changed.

In order to serve our patients chiropractic needs, we need to keep our files current and updated.

Patient Acknowledgment: (Please Sign and Date)

Date: _____

Name: _____

Thank you for your understanding, patience and continued patronage of Ashburn Chiropractic and Rehab Center.

Sincerely,

Dr. Aloysius M. Broussard
Chiropractic Physician & the Staff of Ashburn Chiropractic & Rehab Center