



# World Chiropractic, Inc.

1125 Gaskins Rd., Ste 400, Richmond, VA 23238

Phone: 804-740-3434 - Fax: 804-740-3362

## THIS FORM MUST BE READ AND SIGNED IN ORDER TO SEE THE DOCTOR

### FINANCIAL POLICIES

Our purpose is to provide the very best chiropractic care possible. One of the ways we accomplish this is to eliminate potential problems that may detract from the quality of our work. Therefore we have developed the following financial policies:

We will verify your insurance coverage and review your benefits with you. It is your responsibility to keep up with any maximum limitations that your policy imposes. Keep in mind that verification of benefits is not a guarantee that your insurance company will pay for all services rendered. You may request a copy of your verification page at any time.

As a service to our patients, we bill your insurance company for your treatments. Any unpaid balance that your insurance company has not paid will become your responsibility. Unless otherwise stipulated, the insurance contract is between the patient and the insurance carrier, not between the doctor and the insurance company.

All co-payments and co-insurances **MUST** be paid at the time services are rendered. Should any patient wish to make monthly payment arrangements please see the receptionist for additional information.

A current copy of the patient's insurance card is required in order to file claims. All services received prior to insurance verification must be paid in full at the time services are rendered. When your insurance carrier pays the dates of services in question in full, all over-the-payments will then be credited in the patient's account.

Should your insurance carrier change during the course of treatments or between visits, it is the patient's responsibility to update their insurance information with the billing department. Any claims that must be resubmitted due to non-notification will incur an administrative fee of \$5.00 to the patient.

Any delinquent patient balance will be turned over to our collections division if not paid in full within 60 days of the final insurance payment, accruing late fees, and interest and court costs. Please see attached contract sheet for further information.

### CLAIMS FOR WORKERS COMPENSATION:

Patients should report the injury to the employer immediately after the incident, and you **MUST** have your claim number in order to file medical claims. Your employer may need to fill out information in order to submit claims to the insurance carrier. Workers Compensation cases that are denied may then be submitted to health insurance carriers for payment, or be turned over to the patient's cash balance. If your wish to appeal a denial a monthly payment arrangement will be necessary in order to avoid collection procedures.

### CLAIMS FOR PERSONAL INJURY:

We will file personal injury claims to your auto insurance carrier or health insurance for your treatments. It is not our policy to send claims to any auto insurance carrier other than our patient's insurance carrier.

Due to the length of time it takes to settle personal injury claims; patients will be required to make good faith payments in the amount of \$100 per month. Should patient payments and/or insurance payments result in any overpayment/credits to the account, a refund will be issued once the balance is satisfied.

### SUPPORT & SUPPLIES

The doctor may recommend a support or supply that aids in the recovery of injuries, or assists staff with the application of physical therapy. I understand should I decide to purchase said supports and supplies, my insurance carrier **may determine that the support/supply prescribed for me is not medically necessary (no-allowable)**. Further, I agree to pay for this support/supply even if my insurance carrier decides it is not allowable (**not covered under my benefits**). I will be credited any payment towards the support/supply that my insurance company remits.

# CHIROPRACTIC REGISTRATION AND HISTORY

## 1 PATIENT INFORMATION

Date \_\_\_\_\_  
SS/HIC/Patient ID # \_\_\_\_\_  
Patient Name \_\_\_\_\_  
Last Name \_\_\_\_\_  
First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Address \_\_\_\_\_  
E-mail \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
Sex  M  F Age \_\_\_\_\_  
Birthdate \_\_\_\_\_  
 Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years  
Patient Employer/School \_\_\_\_\_  
Occupation \_\_\_\_\_  
Employer/School Address \_\_\_\_\_  
Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_  
Spouse's Name \_\_\_\_\_  
Birthdate \_\_\_\_\_  
SS# \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

## 2 INSURANCE INFORMATION

Who is responsible for this account? \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Group # \_\_\_\_\_  
Is patient covered by additional insurance?  Yes  No  
Subscriber's Name \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Please print name of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

## 3 PHONE NUMBERS

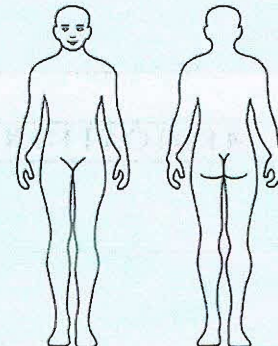
Cell Phone (\_\_\_\_\_) \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_  
Best time and place to reach you \_\_\_\_\_  
**IN CASE OF EMERGENCY, CONTACT**  
Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

## 4 ACCIDENT INFORMATION

Is condition due to an accident?  Yes  No Date \_\_\_\_\_  
Type of accident  Auto  Work  Home  Other  
To whom have you made a report of your accident?  
 Auto Insurance  Employer  Worker Comp.  Other  
Attorney Name (if applicable) \_\_\_\_\_

## 5 PATIENT CONDITION

Reason for Visit \_\_\_\_\_  
When did your symptoms appear? \_\_\_\_\_  
Is this condition getting progressively worse?  Yes  No  Unknown  
Mark an X on the picture where you continue to have pain, numbness, or tingling.  
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_  
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other  
How often do you have this pain? \_\_\_\_\_  
Is it constant or does it come and go? \_\_\_\_\_  
Does it interfere with your  Work  Sleep  Daily Routine  Recreation  
Activities or movements that are painful to perform  Sitting  Standing  Walking  Bending  Lying Down



# 6

## HEALTH HISTORY

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy

Chiropractic Services  None  Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_

Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_

Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

|                     |  |                     |  |                      |  |                              |  |
|---------------------|--|---------------------|--|----------------------|--|------------------------------|--|
| AIDS/HIV            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergy Shots       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sexually Transmitted Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fractures           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Miscarriage          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anorexia            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Suicide Attempt              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Appendicitis        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Goiter              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple Sclerosis   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gonorrhea           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors, Growths              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast Lump         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's Disease  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Typhoid Fever                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pinched Nerve        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bulimia             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herniated Disk      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumonia            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vaginal Infections           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Polio                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Whooping Cough               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts           | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate Problem     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____                  |  |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthesis           | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |  |
| Chicken Pox         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care     | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |  |
|                     |  |                     |  | Rheumatoid Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |  |

### EXERCISE

- None  
 Moderate  
 Daily  
 Heavy

### WORK ACTIVITY

- Sitting  
 Standing  
 Light Labor  
 Heavy Labor

### HABITS

- Smoking \_\_\_\_\_ Packs/Day \_\_\_\_\_  
 Alcohol \_\_\_\_\_ Drinks/Week \_\_\_\_\_  
 Coffee/Caffeine Drinks \_\_\_\_\_ Cups/Day \_\_\_\_\_  
 High Stress Level \_\_\_\_\_ Reason \_\_\_\_\_

Are you pregnant?  Yes  No Due Date \_\_\_\_\_

| Injuries/Surgeries you have had | Description | Date  |
|---------------------------------|-------------|-------|
| Falls                           | _____       | _____ |
| Head Injuries                   | _____       | _____ |
| Broken Bones                    | _____       | _____ |
| Dislocations                    | _____       | _____ |
| Surgeries                       | _____       | _____ |

# 7

## MEDICATIONS

## ALLERGIES

## VITAMINS/HERBS/MINERALS

Pharmacy Name \_\_\_\_\_

Pharmacy Phone (\_\_\_\_) \_\_\_\_\_

MEDICARE PATIENTS

I understand that Medicare does not cover the following services when rendered by a chiropractor, exams, X-rays, ice or heat therapy, electric muscle stimulation, ultrasound and supplies or supports recommended for my condition. In addition, **World Chiropractic, Inc.** will file secondary insurance claims for your convenience.

HIPPA/CONSENT

I understand that **World Chiropractic, Inc.** may use and disclose my protected health information for purposes of treatment, payment, and health care operation. I also acknowledge that I have read, or have received a copy of the Notice of Privacy Practices, which provides information about how **World Chiropractic, Inc** and individuals involved in my care in the practice may use and disclose my protected health information. As stated in the Notice, I understand that I can contact the Privacy Officer at (804) 264-1286 with any questions or concerns.

**World Chiropractic, Inc.** has my permission to share health and account information with the individuals listed below:

| Name: | Relationship |
|-------|--------------|
|       |              |
|       |              |
|       |              |

CONSENT TO TREAT A MINOR

I hereby authorize Dr. Lombardozi and any staff member he may designate as assistants to administer chiropractic care as deemed necessary for my child for the course of my child's treatment.

USUAL & CUSTOMARY RULES

Our practice is committed to providing the best treatment for our patients and our fees are well within what is usual and customary for our area. You are responsible for payment regardless of the insurance company's arbitrary determination of usual and customary rates.

REFERRALS

It is the patient's responsibility to obtain referrals when necessary from their primary care provider prior to treatment. I agree to pay in full for all services rendered without require referral.

**\*\*In consideration for the professional services rendered now and in the future, the undersigned hereby agrees to pay attorney's fees which are hereby stipulated to be 33 1/3 of such outstanding balance whether suit is filed or not; plus court costs. If the undersigned fails to promptly pay for the services rendered, the undersigned authorizes the release by or to nay credit reporting agencies of personal credit information on the undersigned and further agrees to pay all costs of obtaining such credit information and/or locating the undersigned as may be necessary.\*\***

I have read **World Chiropractic, Inc.** Financial and Offices Policies. By signing below I agree to all rules and regulations set forth by this office that applies to my account.

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

\_\_\_\_\_  
Signature of Responsible Party Date

## Terms of Acceptance

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

**Chiropractic has only one goal: to eliminate misalignments within the spinal column, which interfere with the expression of the body's innate wisdom.** It is important that each person 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 of the 24 vertebrae in the spinal column that 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 a disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-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 health care 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 specific adjusting to correct vertebral subluxation.**

**Email Address :**

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## YOUR THOUGHTS ARE CRITICAL TO OUR SUCCESS IN HELPING YOU

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

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

Your nervous system is the master system and controller of your body. Health and wellness are therefore mediated through your nervous system. What makes our office different is that we have a unique and modern approach to supporting and expanding your health by improving how your nervous system performs. The Neurospinal Function EMG Thermography, which is the rating of results of the series of tests with the Insight Technology that your doctor has performed on you.

Lifestyle stress adversely affects your nervous system and general health. Many times, when people think they have a 'back problem', what they really have is a 'health problem' that is a result of the way they are living. Any and all physical events that our body goes through leaves obvious and in most cases not so obvious findings. Therefore, it is important you take time and thoughtfully (as well as honestly) answer all the following questions.

1. On a scale of one to 10 (10 being the most important) how important is your health to you? \_\_\_\_\_

1-----50-----100  
Chronic Illness Optimal Health

2. Please put an 'X' to score where you think you are today?

3. Please circle where you would like to be (your goal).

4. How long do you think it might take to get to where you circled? \_\_\_\_\_

5. What things might you need to change to help you reach your goal?

A: \_\_\_\_\_

B: \_\_\_\_\_

C: \_\_\_\_\_

D: \_\_\_\_\_

6. In what ways does this current problem interfere or reduce your productivity with your daily activities?

\_\_\_\_\_

7. Do you feel older than you actually are? \_\_\_\_\_ How much older? \_\_\_\_\_

8. If this problem was left unattended for another five years, how do you think it would affect you? Would it just disappear?

\_\_\_\_\_

### **WHO DO YOU KNOW THAT NEEDS TO BE CHECKED?**

World Chiropractic • 1125 Gaskins Rd. • Richmond, VA 23238 • 804-740-3434

## POLICIES FOR PATIENTS

To help you receive our best,  
all patients are accepted for care understanding the following office policies:

**PATIENT WORKSHOPS** - To enhance your understanding of chiropractic care and teach you how to get better and faster results, all patients are required to attend *one informative and stimulating Patient Workshops within the first month of care and then one per quarter.* (You are not limited to these required classes.) These workshops are designed to answer your questions and to teach you how to stay healthy naturally. You are encouraged to bring guests so they also can learn about optimal health and healing. There is no additional fee as tuition is already included in our office visit fee structure.

**PREFERRED HOURS** - In order to provide the care you need as conveniently and rapidly as possible, we have established special hours in which you can receive your "adjustments" with as little waiting as possible. Therefore, we ask that you *save detailed questions until your Patient Workshops, schedule a special appointment during our report hours, or request a phone consultation with the doctor.*

**APPOINTMENT SCHEDULING** - To save you time on each visit, we ask that you pre-schedule all appointments in advance and we ask that you refrain from repeatedly rescheduling appointments. In order to keep your progress on schedule, *rescheduled appointments must be made up within the same week.*

**BROKEN APPOINTMENTS** - In order to keep your progress on schedule, missed appointments must be made up within the same week. It is *your responsibility to call us* if you need to make changes to your schedule. **Missed appointments without a 24 hr. notice will result in a \$50 fine billed to the patient's account (Effective 8/10/11).** If you repeatedly miss your appointments or we must continually call you to reschedule your appointments, we will regretfully have to discharge you from our care.

**IN CASE OF ABSENCE** – Dr. Lombardozzi needs to be away from the office several times per year to teach or attend continuing education seminars. During this time we will do our best to not jeopardize the consistency and intensity of your adjustment schedule.

**14- DAY POLICY-** As a new practice member, you are being empowered with health and wellness to not only make a difference in your life but in others as well. Now that you know the importance of getting checked for subluxations, you have 14 days in which your family can get checked.

Initials \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_