



Welcome to Cucci Chiropractic!

Name: _____

Address: _____ City _____ State _____ Zip _____

Phone (H) _____ (W) _____ Email: _____

Date of Birth _____ SSN# _____ - _____ - _____

Employer: _____ Marital Status _____

Referred By: _____

Insurance Information:

Insurance Co. _____ Insurance Co. Tel. # _____

Name of Insured (if different from above) _____

Group # _____ Member # _____

Current Health Condition

Present Complaint/ Reason for Today's

Visit: _____

When did this condition first begin? _____

What aggravates your symptoms ? _____

What alleviates your symptoms? _____

Have you seen other Doctors for this condition? Y/N What did they do? _____

How did you respond? _____

Chiropractic Experience

Have you seen a Chiropractor before? Y/N If yes, When? _____

Reason for Visits: _____ How did you respond? _____

Cucci Chiropractic Policies & Procedures

1. Doctor's Report/ Active Life Plan: During your second visit, you will receive a Chiropractic Doctor's Report and Analysis of your initial visit. Upon completing your review, Dr. Cucci will discuss the different types of Active Life Plans available to you. Chiropractic Active Life plans are bespoke treatment plans designed to help get you feeling better and help you *stay* feeling better through overall maintenance and wellness. In order to help us formulate the best Chiropractic Active Life Plan for you, please describe your short-term and long-term health goals below.

As a result of my chiropractic care, I would like to: (Please circle all that apply)

1. Feel Better Quickly

2. Have a Healthier Body & Immune System

3. Have a Healthier spine

4. Live a Healthier Lifestyle

Other (please describe): _____

2. Informed Consent for Chiropractic Care: I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment. **INITIAL** _____

3. Acknowledgement of Financial Responsibility: I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

INITIAL _____

4. BCBS Remittance of Payment: *FOR PATIENTS COVERED BY BLUECROSS/BLUE SHIELD ONLY* I hereby acknowledge and understand that I have been informed that my insurance carrier may not accept assignment of benefits from my doctor and that insurance payments may be sent to me. I agree not to cash the insurance checks. I also acknowledge that if the checks are cashed and not turned over to Cucci Chiropractic upon receipt, I will be billed for all charges (covered and not covered) with an added interest charge of 2% per month 30 days after the first date of billing to the carrier. I will also be responsible for legal fees, court fees and any other collection fee that my doctor may incur if I failed to comply with the above agreement. CC INFO: Type: _____ CC#: _____ EXP: _____

INITIAL _____

4. Medicare Coverage Requirements: *FOR MEDICARE PATIENTS ONLY* I understand that Medicare requires an examination and x-rays to demonstrate the need for chiropractic care, but they do not cover this expense. They do cover 80% of the charges for adjustments after an annual deductible is met. We will need your Medicare and secondary identification cards to verify your exact coverage with both plans. I understand that I need to make sure that Medicare has my secondary insurance information, as they will not forward claims otherwise.

INITIAL _____

5. Cancellation Policy: I understand that Cucci Chiropractic cancellation policy for all appointments is 24 hours. In the event that I do not contact Cucci Chiropractic via phone or email within 24 hours of my appointment, I acknowledge that I am financially responsible for the visit. **INITIAL** _____

By my signature below, I confirm that I have read and understand the above policies and procedures for Cucci Chiropractic, and I confirm that I am willing and able to comply with these procedures.

Signature: _____

Date: _____