



DATE: ____ / ____ / ____

CHART #: _____

PLEASE CHECK ONE: MR. MRS. MS. DR. REV. FR. SR. PR.

FULL NAME: _____ DATE OF BIRTH: ____ / ____ / ____

AGE: _____ SSN: ____ - ____ - ____ GENDER: _____ MARITAL STATUS: _____

ADDRESS _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ E-MAIL: _____

EMERGENCY CONTACT: _____ PHONE #: _____

BEST SOURCE OF COMMUNICATION: (CHECK ONE) TEXT EMAIL CALL

HOW DID YOU HEAR ABOUT US? _____

PREFERRED LANGUAGE: _____ RACE: _____ ETHNICITY: _____

SMOKING STATUS: (CHECK ONE) CURRENT FORMER NEVER

EMPLOYERS NAME: _____

OCCUPATION: _____ WORK PHONE: _____ EXT: _____

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

RELATIONSHIP TO INSURED: (CHECK ONE) SELF SPOUSE CHILD OTHER: _____

IF SELF; SKIP TO BOTTOM OF FORM. IF SPOUSE, CHILD OR OTHER BE SURE TO FILL OUT ALL OF THE HOLDERS INFORMATION.

NAME OF INSURANCE HOLDER: _____ DATE OF BIRTH: ____ / ____ / ____

ADDRESS: _____

SSN: ____ - ____ - ____ EMPLOYER: _____ PHONE: _____

Authorizations: I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, 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 or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

PATIENT SIGNATURE: _____

DATE: ____ / ____ / ____

GUARDIAN'S SIGNATURE: _____

RELATIONSHIP: _____



DATE: ____ / ____ / ____

FULL NAME: _____

CHART #: _____

Please mark any allergies below:

Amoxicillin	Dairy Products	Latex	Seasonal Allergies
Anesthesia	Dust	Morphine	Shellfish
Animals	Eggs	Nuts	Soaps
Aspirin/Pain Medicine	Erythromycin	Oxycodone	Sulfa
Bug Bites	Fish	Peanuts	Tylenol
Chlorine	Gluten	Penicillin	Vicodin
Chocolates/Sweets	Iodine	Percocet	Other:
Codeine	Lactose Intolerance	Ragweed/Pollen	_____

Please mark any surgeries below:

Abdomen	Carpal Tunnel	Hernia	Spleen
ACL	Circumcision	Hip	Tonsils removed
Adnoids removed	C-Section	Hysterectomy	Tubal ligation
Ankle	Ear	Knee	Vasectomy
Appendix	Eyes	Neck	Wisdom teeth
Back	Foot	Nose	Wrist/Hand
Bladder	Gall Bladder	Oral	Other:
Brain/Tumor	Gastric Bypass	Shoulder	_____
Breast	Heart	Sinus	

Please mark any past medical history conditions below:

Acid Reflux	Ear Infections	High Cholesterol	Parkinson's Disease
Allergies	Eczema	Hip Pain	Prostate Problems
Ankle Pain	Elbow Pain	Jaw Pain	Psoriasis
Anxiety	Endometriosis	Joint Stiffness	Sciatica
Arm Pain	Epilepsy	Kidney Stones	Scoliosis
Arthritis	Eye/Vision Problems	Knee Pain	Seizures
Asthma	Fatigue	Leg Pain	Shoulder Pain
Back Pain	Fibromyalgia	Low Back Pain	Significant Weight Change
Bi-Polar Disorder	Foot Pain	Lyme Disease	Spinal Cord Injury
Broken Bones	Genetic Spinal Disorder	Menstrual Problems	Sprain/Strain
Cancer	GERD	Mid Back Pain	Stroke/Heart Attack
Carpal Tunnel Syndrome	Hand Pain	Multiple Sclerosis	Thyroid Problems
Constipation	Headaches	Neck Pain	Whiplash
Depression	Hearing Problems	Neurological Disorder	Wrist Pain
Diabetes	Heart Problems	Osteoarthritis	Other:
Difficulty Breathing	Heartburn/Indigestion	Osteoporosis	_____
Dizziness	High Blood Pressure	Pacemaker	



DATE: ____ / ____ / ____

FULL NAME: _____

CHART #: _____

Please list any medications you are currently taking and why:

Please list any vitamins or supplements you are currently taking:

Please list any Family History Medical Conditions and Who they Relate to:
(Refer to Medical Conditions Above — Example: Mom: high blood pressure)

Have you had any Auto or other accidents? Yes No *If yes, please describe below:*

Who is your Primary Care Physician? _____ Date of Last Exam? ____ / ____ / ____

Are you pregnant? Yes No How many weeks? _____ Due Date: ____ / ____ / ____

Who is your Midwife/Obgyn? _____

Do you smoke? Yes No Packs per day? ____ Do you use other drugs/substances? Yes No

Do you drink alcohol? Yes No Drinks per day? ____

Do you drink caffeine? Yes No Drinks per day? ____

Do you Exercise? Yes No *If yes, please describe what forms and how often below:*

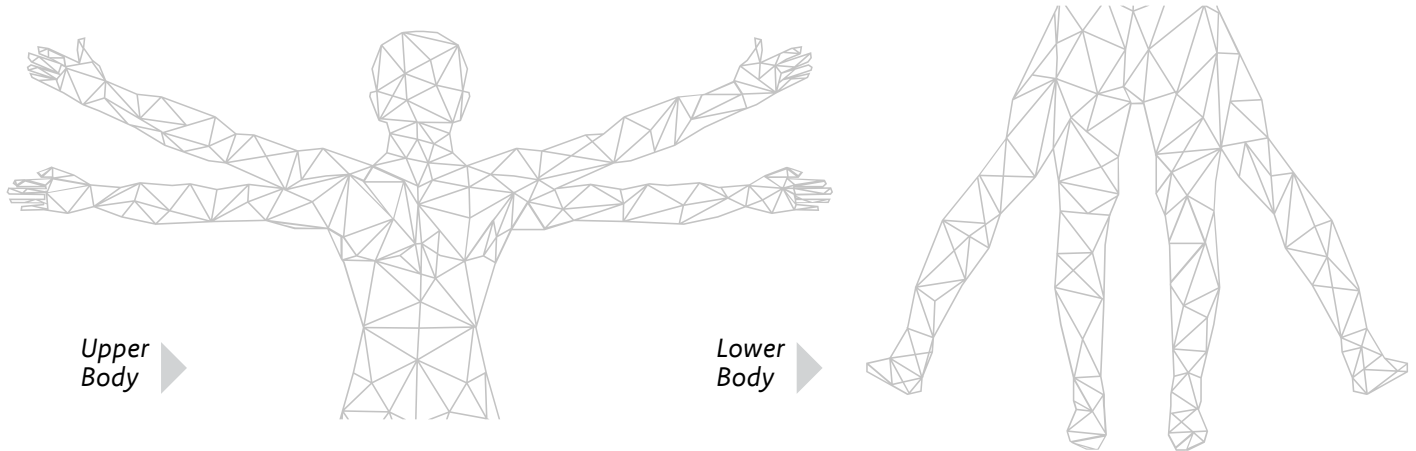


DATE: ____ / ____ / ____

FULL NAME: _____

CHART #: _____

Please mark your areas of pain on the diagram(s) below:



What is your MAJOR complaint? _____ Date problem began? ____ / ____ / ____

How did this problem begin (falling, lifting, etc.)? _____

Which side is the problem occurring? Right Left Both Center

Have you had this condition in the past? Yes No

Please rate your pain on a scale of 1 to 10 (0 = no pain and 10 = excruciating pain)

1 2 3 4 5 6 7 8 9 10

Is the pain: Mild Moderate Severe Unbearable

Describe the nature of your symptoms:

Sharp Dull Numb Burning Shooting Tingling Radiating Pain Tightness

Stabbing Throbbing Other: _____

What makes your pain better (ice, heat, massage, etc)? _____

How often do you experience your symptoms?

Constantly (76-100% of the day) Frequently (51-75% of the day)

Occasionally (26-50% of the day) Intermittently (0-25% of the day)

What activities aggravate your condition (working, exercise, etc)? _____



DATE: ____ / ____ / ____

FULL NAME: _____

CHART #: _____

What is your SECOND complaint? _____ Date problem began? ____ / ____ / ____

How did this problem begin (falling, lifting, etc.)? _____

Which side is the problem occurring? Right Left Both Center

Have you had this condition in the past? Yes No

Please rate your pain on a scale of 1 to 10 (0 = no pain and 10 = excruciating pain)

1 2 3 4 5 6 7 8 9 10

Is the pain: Mild Moderate Severe Unbearable

Describe the nature of your symptoms:

Sharp Dull Numb Burning Shooting Tingling Radiating Pain Tightness

Stabbing Throbbing Other: _____

What makes your pain better (ice, heat, massage, etc)? _____

How often do you experience your symptoms?

Constantly (76-100% of the day) Frequently (51-75% of the day)

Occasionally (26-50% of the day) Intermittently (0-25% of the day)

What activities aggravate your condition (working, exercise, etc)? _____



DATE: ____ / ____ / ____

FULL NAME: _____

CHART #: _____

What is your NEXT complaint? _____ Date problem began? ____ / ____ / ____

How did this problem begin (falling, lifting, etc.)? _____

Which side is the problem occurring? Right Left Both Center

Have you had this condition in the past? Yes No

Please rate your pain on a scale of 1 to 10 (0 = no pain and 10 = excruciating pain)

1 2 3 4 5 6 7 8 9 10

Is the pain: Mild Moderate Severe Unbearable

Describe the nature of your symptoms:

Sharp Dull Numb Burning Shooting Tingling Radiating Pain Tightness

Stabbing Throbbing Other: _____

What makes your pain better (ice, heat, massage, etc)? _____

How often do you experience your symptoms?

Constantly (76-100% of the day) Frequently (51-75% of the day)

Occasionally (26-50% of the day) Intermittently (0-25% of the day)

What activities aggravate your condition (working, exercise, etc)? _____

PREVIOUS CHIROPRACTIC CARE?

Have you ever had chiropractic care? Yes No Where: _____ When: ____ / ____ / ____

Why? _____

Were X-rays taken? Yes No

When was your last adjustment: ____ / ____ / ____



CHART #: _____

Release Form for individuals involved in care of Patient

I, _____, give SCWC permission to speak with the following people regarding my health status, including diagnosis, treatment options and plans and payment for health services I receive from SCWC. I also allow the following people to discuss information about my appointments.

This consent is valid until such time as I provide SCWC written revocation of it.

PATIENT NAME: _____ DOB: _____

SCWC may speak with:

NAME: _____ DOB: _____ RELATIONSHIP: _____

ADDRESS: _____

NAME: _____ DOB: _____ RELATIONSHIP: _____

ADDRESS: _____

NAME: _____ DOB: _____ RELATIONSHIP: _____

ADDRESS: _____

By signing this form, I authorize Sasseville Chiropractic Wellness Center to share my personal health information listed above to the person(s) or organization(s) I named on this form. I understand that my personal health information may be shared by the person(s) or organization(s) and may no longer be protected by law.

PATIENT NAME: _____ DATE: ____ / ____ / ____

PARENT/GUARDIAN SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____



DATE: ____ / ____ / ____

PATIENT NAME: _____

CHART #: _____

I do not wish to receive office notes for each of my chiropractic visits. I understand that by signing this document I am allowing Sasseville Chiropractic Wellness Center to omit asking if I need my office notes each time I come in.

I also understand that by signing this document that I will need to let Sasseville Chiropractic Wellness Center know if I need office notes for any future visits as they are available any time I need.

PATIENT/GUARDIAN SIGNATURE: _____

SCWC REPRESENTATIVE SIGNATURE: _____



CHART #: _____

HIPAA Omnibus Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred, DME vendors, surgery centers/hospitals, referring physicians, family practitioner, physical therapists, home health providers, laboratories, worker comp adjusters and nurse case managers, etc to ensure that the healthcare provider has the necessary information to diagnose or treat you.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay, surgery, MRI or other diagnostic test, injection procedures, injection series, physical therapy, etc., may require that your relevant protected health information be disclosed to the health plan to obtain approval for the procedure.

HEALTHCARE OPERATIONS: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office.

In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.(this could be done by phone, email or mail). We use closed treatment rooms but you may still be in ear shot of other patients. Your initial and follow up evaluation notes will be sent to your Primary Care Physician.

If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in. We may disclose your health information to notify or assist in notifying a family member or another person responsible for your care about your medical condition or in the event of an emergency or of your death. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues and safety as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers’ compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Mainecare Benefits. In the event that Sasseville Chiropractic Wellness Center is sold or merged with another organization, your health information/records will become the property of the new owner.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.



CHART #: _____

Cancellation / No Show Policy / Emergency Appointments

1. Cancellation/No Show Policy for Appointments

We understand there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book. Typically there are patients on a wait list for these services that could have been scheduled if given appropriate advanced notice.

If an appointment is not cancelled at least 24 hours in advance, you will be charged a \$100 fee; this will not be covered by your insurance company.

After 3 no call no show/missed appointments in a row, the patient is released from active care.

2. Scheduled Appointments

We understand that delays can happen, however, we must try to keep the other patients and doctors on time. We expect patients to arrive at least 5 minutes prior to their scheduled appointment.

If a patient is 10 minutes past their scheduled time, we will have to reschedule the appointment. This will be considered a last minute cancellation and will result in a missed appointment, you will be charged a \$100 fee; this will not be covered by your insurance company.

3. After hours and Emergency Appointments

If the need arises for you to be seen by a SCWC provider outside of their normal SCWC hours, you will be charged an after-hours/emergency fee. “Outside of normal SCWC hours care” refers to any care provided by a provider that is scheduled outside of their typical schedule hours. Our office is closed every Thursday, weekends, and all major holidays.

If you need emergency or after hours care, there will be an additional \$150 fee along with any service charges from your treatment; this fee will not be covered by your insurance company.

PATIENT NAME PRINTED: _____ DATE: ____ / ____ / _____

PATIENT SIGNATURE: _____



CHART #: _____

Payment Policy

Payments are expected at each appointment and can be paid via credit/debit card deductible. Please fill out the form below with credit/debit card information and choose the type of payments you authorize.

PATIENT NAME: _____

Please initial to Agree to:

_____ Payment for copay or estimate cost per visit at each appointment.

_____ Automatically pay any outstanding balances after claims process through Insurance.

I agree that Sasseville Chiropractic Wellness Center may charge my credit card on file for the balance due when they receive a copy of the EOB from my Health Insurance carrier. This authorization relates to all balances not covered by my insurance company for services provided by Sasseville Chiropractic Wellness Center. This could be amounts resulting from balances of copayment, deductible, co-insurance, non-covered or denials for no coverage, however is not limited to these scenarios.

I understand that this authorization is valid until such time as I provide a 30-day written notice to cancel the authorization. Written notice must be submitted to the address below for processing.

CHECK ONE: MASTERCARD VISA AMEX DISCOVER

CREDIT CARD #: _____ EXP. DATE: ____ / ____ / _____

PRINTED NAME ON CARD: _____

PATIENT SIGNATURE: _____ DATE: ____ / ____ / _____



DATE: ____ / ____ / ____

Non-Medicare Advanced Beneficiary Notice (ABN)

PATIENT NAME: _____ DOB: _____ CHART #: _____

Your insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need.

Services below may NOT be payable by your medical plans and would need to be Paid At Time of Service.

Appropriate copays need to be **paid at time of service**.

Items below list the estimated cost that will be billed to your insurance company. Any of these services provided that do not get paid by your insurance, will be considered **Patient Responsibility**.

TREATMENT	EST. COST	TREATMENT	EST. COST
Acupuncture	Up to \$400	New Patient Exam	Up to \$350
After hours/emergency care	\$150	Orthotics	\$85-\$500
Consultations	Up to \$175	Re-evaluations	Up to \$250
Distraction	\$30	Spinal Adjustments	\$55-\$125
Kinesiotape/Posture Rehab/Tex	\$55	Extra Spinal Adjustment	\$50
MT/NMR Therapy	\$110-\$210	Wellness Care	Up to \$500
Muscle Stimulation Therapies	Up to \$50	X-rays	\$80-\$150

WHAT YOU NEED TO DO NOW

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Please draw a line through any service you DO NOT want performed.
- Recognize that by signing below, this covers any and all visits from January 1 to December 31, 2026.

Additional information: If you have a managed care plan (HMO), you will need a referral from your primary care provider (PCP). Any unpaid services are your financial responsibility.

Signing below means that you have received and you understand this notice.

PATIENT SIGNATURE: _____ DATE: ____ / ____ / ____



CHART #: _____

Dear Patient:

We are always happy to submit a claim to your insurance company for services rendered. However, your insurance company may not cover any service, unless you obtain a referral from your Primary Care Physician. (Please consult your member handbook regarding referrals from your Primary Care Physician)

It is your responsibility to obtain a referral. Your signature below indicates that if you receive specialty care without consent of your Primary Care Physician, you will assume financial responsibility.

Thank you.

PATIENT NAME: _____ DATE: ____ / ____ / _____

PATIENT/GUARDIAN SIGNATURE: _____

SCWC REPRESENTATIVE SIGNATURE: _____