



### SECTION 1.

### ABOUT YOU

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Mid. Init.) \_\_\_\_\_

Birthday: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female Social Security #:\* \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Phone #:\*\*  Home \_\_\_\_\_  Cell \_\_\_\_\_  Work \_\_\_\_\_

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

Status:  Minor  Single  Married  Partnered  Divorced  Separated  Widowed

If Married, Spouse's Name: \_\_\_\_\_ # of Children: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

*\*Optional \*\*Check best contact number*

### SECTION 2.

### PAYMENT (select one)

**Insurance** Insurer's Name (if other than self): \_\_\_\_\_ Insurer's DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Primary: \_\_\_\_\_ Policy #: \_\_\_\_\_ Secondary: \_\_\_\_\_ Policy #: \_\_\_\_\_

**Auto/Personal Injury** Auto Insurance Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

Claim #: \_\_\_\_\_ Adjuster's Name: \_\_\_\_\_

Adjuster's Ph. #: \_\_\_\_\_ Adjuster's Fax #: \_\_\_\_\_

Attorney Name (If Applicable): \_\_\_\_\_ Attorney Phone #: \_\_\_\_\_

**Selfpay**  **Other (Please Specify)** \_\_\_\_\_

### SECTION 3.

### HEALTH HISTORY

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Are you Taking Any Medications?  Yes  No If yes, please list \_\_\_\_\_

Have you ever had an MRI of your spine?  Yes  No If yes, when \_\_\_\_\_

Do you have or ever had any of the following diseases or conditions? (mark: **y** for yes **n** for no)

<input type="checkbox"/> Alcohol/drug abuse	<input type="checkbox"/> Congenital heart defect	<input type="checkbox"/> Frequent neck pain	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Sciatica
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes/tuberculosis	<input type="checkbox"/> Heart attack/stroke	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Severe/frequent headaches
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Leg/Arm Pain	<input type="checkbox"/> Shingles
<input type="checkbox"/> Artificial bones/joints	<input type="checkbox"/> Dislocations	<input type="checkbox"/> Heart surgery/pacemaker	<input type="checkbox"/> Lower back problems	<input type="checkbox"/> Sinus problems
<input type="checkbox"/> Artificial valve	<input type="checkbox"/> Emphysema/Glaucoma	<input type="checkbox"/> Herniated Disc	<input type="checkbox"/> Mitral valve prolapse	<input type="checkbox"/> Snoring
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fainting/seizures/epilepsy	<input type="checkbox"/> High/low blood pressure	<input type="checkbox"/> Psychiatric diagnoses	<input type="checkbox"/> Ulcer/colitis
<input type="checkbox"/> Cancer/Chemotherapy	<input type="checkbox"/> Fractures	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Venereal disease

List any other serious medical condition(s) that we should know about: \_\_\_\_\_

List any past serious accidents or surgeries and include the dates: \_\_\_\_\_

List allergies: \_\_\_\_\_

Do you exercise?  Yes \_\_\_\_\_ times/day  No What exercise activities do you do? \_\_\_\_\_

Do you: • smoke?  Yes \_\_\_\_\_ times/day  No • drink alcohol?  Yes \_\_\_\_\_ times/week  No • drink coffee?  Yes \_\_\_\_\_ cups/day  No

Do you take supplements (i.e. vitamins, minerals, herbs)? List them: \_\_\_\_\_

**FOR WOMEN:** Have children?  Yes  No Taking birth control?  Yes  No Pregnant?  Yes  No Nursing?  Yes  No



**SECTION 4.**

**REASON FOR VISIT**

The reason for this visit is a result of  Work  Auto  Trauma  Chronic  Other (*Explain*): \_\_\_\_\_

Please describe the pain and its location: \_\_\_\_\_

When did the condition begin? \_\_\_\_\_ This condition is:  Constant  Intermittent  Activity related

Condition is interfering with:  Work  Sleep  Hobbies  Daily routine If so please explain: \_\_\_\_\_

What activities aggravate your symptoms? \_\_\_\_\_ Condition getting worse?  Yes  No

Is there anything, which has relieved your symptoms?  Yes  No (*Describe*) \_\_\_\_\_

Have you experienced this condition before?  Yes  No If so please explain: \_\_\_\_\_

Who have you seen for this? \_\_\_\_\_

What did they do? \_\_\_\_\_ How did you respond? \_\_\_\_\_

Are there activities you cannot do as a result of your problem/pain?  Yes  No (*Describe*) \_\_\_\_\_

**SECTION 5.**

**CHIROPRACTIC HISTORY (if applicable)**

What is your goal here at Terrapin Care Center? \_\_\_\_\_

Have you ever been treated by a chiropractor before?  Yes  No If so, whom? \_\_\_\_\_ When? \_\_\_\_\_

Did your previous chiropractor take before and after x-rays?  Yes  No

Please circle the number corresponds with your pain today overall. 1= No pain 10= Worst pain imaginable

1 2 3 4 5 6 7 8 9 10

Please circle the number corresponds with your pain at its worst. 1 2 3 4 5 6 7 8 9 10

Is there any time during the day that you have no pain?  Yes  No

Do you ever "pop or crack" your own neck or back?  Yes  No

Do you snore at night?  Yes  No Do you ever experience numbness or tingling in your hands/feet?  Yes  No

Do your feet ever bother you?  Yes  No Do you sometimes feel like one leg is longer than the other?  Yes  No

Is there any anything else we should know or you'd like to add? \_\_\_\_\_

**SECTION 6.**

**RADIOGRAPH CONSENT, APPOINTMENT POLICY, AUTHORIZATION FOR TREATMENT**

I \_\_\_\_\_ hereby give my consent to allow Terrapin Care Center and it's representatives as deemed by the examining physician to take radiographs (x-rays) of my spine and/or extremities

**For Women:** I also hereby declare that to my knowledge I am not pregnant \_\_\_\_\_ (Initial)

Signature of Patient or Guardian of said Minor \_\_\_\_\_ Date \_\_\_\_\_

Missed appointments without prior notification will result in a \$25.00 cancellation fee. We apologize for any inconvenience this may cause, but each patient's time with the doctor/therapist is valuable. If you need to reschedule your appointment, kindly give us a courtesy phone call, so we are able to open up the timeslot for other patients.

Signature of Patient or Guardian of said Minor \_\_\_\_\_ Date \_\_\_\_\_

I authorize and agree to allow the doctor and/or physical therapist to examine and treat me for the purpose of postural and structural restoration of normal biomechanical, neurological function, and reduction of pain.

The doctor and/or physical therapist will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the medical and spinal structural conditions diagnosed at this clinic.

I authorize the assignment of all insurance benefits to be directed to the doctor and/or physical therapist for all services rendered.

Signature of Patient or Guardian of said Minor \_\_\_\_\_ Date \_\_\_\_\_



**SECTION 7.**

**NOTICE OF PRIVACY PRACTICES**

The following authorizes Terrapin Care Center to use and/or disclose protected health care information in accordance with the following specific authorizations:

I give permission to Terrapin Care Center to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective healthcare information during the course of my treatment. Should I need to speak with the doctor/physical therapist in private, the doctor/physical therapist will provide a private room for these conversations.

By signing the following you are giving Terrapin Care Center permission to use and disclose your protected health information in accordance with the directives listed in the "Authorization for Treatment" section. Information you provide may be used for:

- Treatment
- Payment
- Appointments

\_\_\_\_\_ (Initial) I authorize Terrapin Care Center to notify me of appointments by email or text appointment reminders, per my request. And I authorize Terrapin Care Center to email my x-rays and medical records, upon my request. I understand that records sent through unencrypted email pose a security risk but it is my requested method.

\_\_\_\_\_ (Initial) I understand and have been provided with a notice of information practices that provides me with a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health care information for directory purposes
- The right to request restrictions as to how my health care information may be used or information may be used or disclosed in this office to carry out treatment, payment, or health care operations

Signature of Patient or Guardian of said Minor \_\_\_\_\_ Date \_\_\_\_\_

**SECTION 8.**

**PAYMENT POLICY, INSURANCE POLICY**

In order to keep our fees from rising and at the same time keep up with the monumental expenses of bookkeeping and billing services, we have opted to offer our patients these payment policies.

1. Payment is expected at the time services are rendered. Our office accepts cash, Visa, Mastercard, Discover, American Express, and checks.
2. Non-insured patients are expected to make payments in full on the day the service is rendered, unless definite arrangements have been made with the doctor in advance.
3. Patients with insurance are expected to pay their patient portion of the total fee not covered by their insurance on the day of service. This "patient portion" is ONLY an estimated dollar amount.
4. At your request, the doctor will discuss the charges with you before care begins.

We bill patients on a monthly basis. All accounts not paid within 90 days will automatically be put through to an outside collections agency, which may affect your credit. In case of financial difficulty, please let us know so that a manageable payment schedule can be worked out.

Signature of Patient or Guardian of said Minor \_\_\_\_\_ Date \_\_\_\_\_

1. You are considered to be a cash patient until our office qualifies your coverage to determine the extent of benefits under your policy. As a COURTESY, our office will file your claim with your insurance company, and initiate correspondence with the purpose of getting you the maximum coverage your insurance will allow; however, the payment is ultimately your responsibility.
2. All deductible payments must be made prior to insurance submittal. Please contact your insurance company to verify your coverage.
3. All co-payments must be paid in full at the time of service.
4. Should you discontinue care for any reason other than discharge by the doctor, any and all balances due will become immediately payable in full, regardless of any claims submitted.
5. This office does not promise that insurance company will reimburse you for the usual and customary charges submitted by this office, nor will we enter into any dispute with an insurance company over the amount of reimbursement.

Signature of Patient or Guardian of said Minor \_\_\_\_\_ Date \_\_\_\_\_



**Terrapin Care Center**  
9658 Baltimore Ave, Suite 420, College Park, MD  
Tel: 301.220.1930 • Fax: 301.220.1906  
www.terrapiincarecenter.com

### CHIROPRACTIC SERVICES - INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic services and other procedures within the scope of the practice of chiropractic on me (or on the patient named below, for whom I am legally responsible) by the chiropractor named below and/or other licensed chiropractor who now or in *the* future treat me while employed by, working or associated with or serving as back-up for the chiropractor named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that the primary treatment used by doctors of chiropractic is spinal manipulative therapy. The doctor will use that procedure to treat you. He or she may use her hands or mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

I understand that methods of treatment may include, but are not limited to, spinal manipulative therapy, palpation, instrument adjustments, range of motion testing, orthopedic testing, neurological testing, muscle strength testing, postural analysis testing, laser therapy, assisted isolated stretching, exercises, power plate exercises, cryotherapy, electric muscle therapy, and traction therapy.

I have been informed that chiropractic treatment is a generally safe method of treatment, but that it may have some side effects, as with any other healthcare procedure. As with any other healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy that are very rare such as fractures or minor muscle pulls. It is common to feel stiffness or soreness following the first few days of treatment. Fractures are very rare occurrences and generally result from some underlying weakness of the bone. Stroke or vertebral artery dissection caused by chiropractic manipulation of the neck has not been officially proven but continues to be anecdotal. The doctor will make every reasonable effort during the examination to screen for contraindications to care, however if you have a condition that would not come to the Doctor's obvious attention, it is your responsibility to inform the doctor.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of chiropractic treatment and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

\_\_\_\_\_  
Signature of Patient/Legal Representative

\_\_\_\_\_  
Print or Type Name Here

\_\_\_\_\_  
Date

**Provider: I certify that I have explained to the patient (or legally responsible agent) his/her condition, the proposed operation(s)/treatment(s) attendant risk and possible discomforts involved, other methods of treatment, and the possibility of complications.**

**Electronically signed by Levy Riley, D.C.**

**Electronically signed by Sean Rowland, D.C.**