GONSTEAD CHIROPRACTIC CENTER
DR. RICH BENJAMIN, D.C.
1698 HWY 160 WEST SUITE 140
FORT MILL, SC 29708

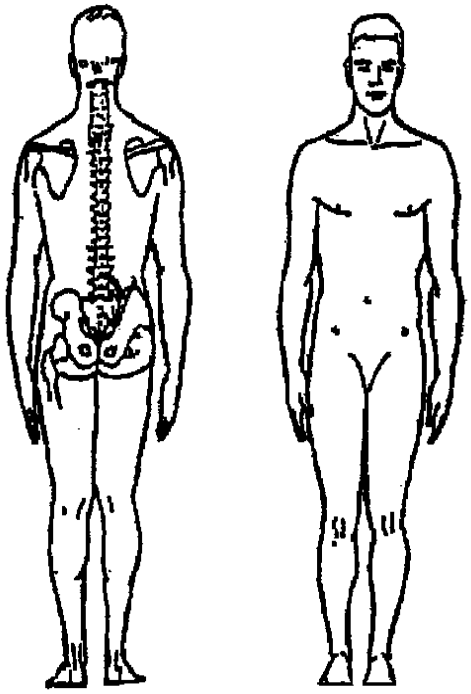
COMPLETE ALL QUESTIONS. PLEASE PRINT.

TODAY'S DATE _____

NAME _____ HOME PHONE _____ WORK PHONE _____
CELL PHONE _____ ADDRESS _____
CITY _____ STATE _____ ZIP _____AGE ____ BIRTH DATE _____
MARITAL STATUS: S M W D NUMBER OF CHILDREN ____

CIRCLE PAYMENT TYPE: CASH/CHECK /MASTER CARD/VISA WE DO NOT ACCEPT AMERICAN EXPRESS
YOUR EMPLOYER _____ OCCUPATION _____ YEARS ON JOB __
EMPLOYER ADDRESS _____ CITY _____ STATE ____ ZIP _____

NAME OF EMERGENCY CONTACT _____ PHONE # _____
RELATIONSHIP TO EMERGENCY CONTACT: _____
CURRENT PRESCRIPTION DRUGS/MEDICATION YOU ARE ON OR HAVE ARE TAKEN IN THE PAST:
_____
_____



COMPLETE THESE DIAGRAMS

IF YOU ARE IN PAIN, PLEASE MARK THE EXACT LOCATION OF YOUR PAIN ON THE DIAGRAM. ALSO DESCRIBE THE TYPE AND FREQUENCY OF YOUR PAIN, AS WELL AS ANY ACTIVITY WHICH BRINGS ON OR AGGRAVATES THE PAIN. FOR EXAMPLE; DULL, SHARP, CONSISTENT, OFF & ON, WHEN STANDING, WHEN SITTING, ETC.....

MAJOR COMPLAINTS

(PLEASE LIST ANY CONDITION YOU ARE BEING TREATED FOR OR ARE EXPERIENCING.)

_____
_____
_____
_____
_____
_____

HAVE YOU HAD ANY PREVIOUS EXPERIENCE WITH CHIROPRACTIC CARE? IF SO, PLEASE EXPLAIN:

_____

IS YOUR CONDITION DUE TO AN ACCIDENT? YES ____ NO ____
DATE OF ACCIDENT? _____

TYPE OF ACCIDENT? AUTO ____ WORK/ON JOB ____ AT HOME ____ OTHER _____
HAVE YOU EVER BEEN IN AN AUTO ACCIDENT? Y / N
PAST YEAR ____ PAST 5 YEARS ___ OVER 5 YEARS ___

REFERRED TO OUR OFFICE BY: _____

GONSTEAD CHIROPRACTIC CENTER

Gonstead Chiropractic Center is not a provider of any one insurance. It is important that there be a clear understanding of this, and as a result, a clear understanding of what our procedures are regarding insurance.

You will always be informed of what procedures will be performed before they occur, and you will be informed of the fees associated with those procedures. You are responsible for payment on the date of services, unless prior arrangements are made **before** seeing the Doctor.

We do not process insurance forms at this office, nor do we have interactions with insurance companies, whether medical, car, or workman's compensation. Each month we can provide you with an itemized receipt (a "Superbill") with all of the necessary codes and information for you to submit to your insurance company. Your insurance company may reimburse you for a portion of your office visit if you have out-of-network benefits. You assume sole responsibility for obtaining the receipt from us, interacting with your insurance company, and pursuing reimbursement. We do not guarantee reimbursement, although many of our patients do have success.

Ultimately your health choices are yours alone, not any insurance company, their representatives, or a policy manual.

By signing this form, you acknowledge that you are responsible for payment of services rendered at Gonstead Chiropractic Center and there is no guarantee that your insurance company will reimburse you for any procedures and treatment.

_____

Patient Signature

_____

Patient Name

_____

Date

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OFFICE FINANCIAL POLICIES:

PLEASE INITIAL

_____ GONSTEAD CHIROPRACTIC CENTER IS A CASH PRACTICE. FULL PAYMENT IS DUE EACH VISIT. IF FOR ANY REASON THIS REQUEST CANNOT BE MET, ARRANGEMENTS SHOULD BE MADE IN ADVANCE BEFORE SEEING THE DOCTOR. PAYMENT OPTIONS INCLUDE CASH, CHECK, OR CREDIT/DEBIT CARD. **WE DO NOT ACCEPT AMERICAN EXPRESS**.

_____ APPOINTMENTS SCHEDULED OUTSIDE REGULAR OFFICE HOURS WILL BE AN ADDITIONAL $25 CHARGE.

_____ COPIES OF DIGITAL FILMS CAN BE REQUESTED FOR A $15 FEE.

_____ WRITTEN REPORTS FOR A THIRD PARTY MAY BE REQUESTED FOR A $20 FEE PER REPORT

_____ **WE DO NOT PROCESS INSURANCE FORMS AT THIS OFFICE. WE WILL GLADLY GIVE YOU AN ITEMIZED RECEIPT (A SUPER BILL) WITH ALL NECESSARY INSURANCE CODES FOR YOU TO SUBMIT TO YOUR INSURANCE COMPANY. THEY WILL REIMBURSE YOU ACCORDING TO THEIR POLICIES. WE DO NOT GUARANTEE THE INSURANCE COMPANY WILL REIMBURSE YOU. THE PATIENT ASSUMES SOLE RESPONSIBILITY FOR INTERACTING WITH THE INSURANCE COMPANY AND PURSUING REIMBURSEMENT.**

_____WE DO NOT ACCEPT PI CASES OR WORKER'S COMPENSATION CASES. IF YOU FALL UNDER THESE CATEGORIES, THE DOCTOR WILL GLADLY PROVIDE SERVICES FOR YOU, BUT PAYMENT WILL BE REQUIRED FOR SERVICES THAT ARE RENDERED.

_____WE CURRENTLY DO NOT FILE MEDICARE. WE DO NOT ACCEPT MEDICAID.

CONSENT FOR TREATMENT AND AUTHORIZATION TO PERFORM X-RAYS

_____I AUTHORIZE DR. RICH BENJAMIN TO PERFORM ANY DIAGNOSTIC RADIOGRAPHIC EXAMINATION IF THEY ARE ADVISABLE IN MY CASE SO THAT A COMPLETE ANALYSIS CAN BE MADE OF MY MUSCULOSKELETAL PROBLEM (OR ILLNESS).

_____I AUTHORIZE DR. RICH BENJAMIN TO ADMINISTER WHATEVER TREATMENT IS DEEMED NECESSARY TO TREAT MY PRESENT PROBLEM OR ILLNESS.

_____SIGNATURE OF PATIENT

_____ DATE

TO THE BEST OF MY KNOWLEDGE I AM NOT PREGNANT AND DR. RICH BENJAMIN HAS MY PERMISSION TO X-RAY FOR DIAGNOSTIC PURPOSES.

_____SIGNATURE OF PATIENT

_____DATE

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PATIENT VOICEMAIL/E-MAIL CONSENT FORM

GONSTEAD CHIROPRACTIC CENTER IS REQUIRED TO OBTAIN PRIOR AUTHORIZATION TO LEAVE DETAILED VOICEMAIL MESSAGES FOR THE PATIENT. THIS POLICY IS TO PROTECT THE PATIENT AND ALSO TO PROTECT OUR STAFF FROM VIOLATING THE PATIENT'S CONFIDENTIALITY. IF WE DO NOT HAVE A SIGNED CONSENT FORM ON FILE, THE STAFF MAY LEAVE ONLY THEIR NAME AND A PHONE NUMBER ON AN ANSWERING MACHINE ASKING YOU TO CALL THEM BACK. BY COMPLETING THE CONSENT BELOW, YOU HEREBY AUTHORIZE THE STAFF TO CALL AND LEAVE THEIR NAME, DOCTOR'S NAME, AND ADDITIONAL INFORMATION ON AN ANSWERING MACHINE OR WITH A SPECIFIC INDIVIDUAL. YOU ALSO AUTHORIZE THE STAFF TO CONTACT YOU BY E-MAIL. NO PRIVATE INFORMATION BE SHARED ON THE WEB, ONLY INFORMATIVE INFORMATION). UNLESS NOTIFIED IN WRITING, THIS CONSENT WILL REMAIN IN EFFECT PERMANENTLY.

I DO / DO NOT (CIRCLE ONE) GIVE MY CONSENT TO GONSTEAD CHIROPRACTIC CENTER TO LEAVE A MESSAGE REGARDING APPOINTMENT DATES AND TIMES OR OTHER NECESSARY INFORMATION.

(CIRCLE Y/N)

1 – ON ANSWERING MACHINE AT HOME YES / NO

2 – ON VOICEMAIL AT WORK YES / NO

3 – ON CELL PHONE VOICEMAIL YES / NO

PLEASE LIST THE NAME OF ANY INDIVIDUAL WE CAN RELEASE **ANY** OF YOUR INFORMATION (APPOINTMENT DATES AND TIMES, ETC.) TO:

_____ _____
NAME/RELATIONSHIP NAME/RELATIONSHIP

PLEASE NOTE THAT **ONLY YOU THE PATIENT** MAY CALL TO CHANGE YOUR APPOINTMENT. A PARENT/GUARDIAN MAY CALL TO CHANGE THE APPOINTMENT OF THEIR CHILD, HOWEVER. _____ (PLEASE INITIAL).

EMAIL ADDRESS BELOW FOR IMPORTANT OFFICE UPDATES, INCLUDING EMERGENCY CLOSINGS:

_____

GONSTEAD CHIROPRACTIC CENTER IS ADVANCING THE WAY WE SEND INFORMATION. WE WANT TO KEEP YOU UPDATED ON ALL OF THE NEW AND INNOVATIVE SERVICES WE OFFER HERE AT. WE WANT YOU TO JOIN US! PLEASE CIRCLE ANY OF THE FOLLOWING YOU ARE WILLING TO JOIN US ON.

1 – FACEBOOK "LIKE" US ON FACEBOOK AT GONSTEAD CHIROPRACTIC CENTER!
2 – E-MAIL NEWSLETTER _____(EMAIL)

_____ _____
PRINTED PATIENT NAME SIGNATURE OF PATIENT

_____ DATE

Family Health History

Many health problems are hereditary or environmental in nature. Please check any items that are recurrent health problems in your family. Leave blank those that do not apply.

Patient _____ Date_____

Condition	Father	Mother	Brother	Sister	Children
ADD/ADHD					
Arthritis					
Asthma/Hay Fever/Allergies					
Back Trouble					
Bursitits					
Cancer					
Constipation					
Diabetes					
Disc Problems					
Emphysema					
Seizures					
Headaches					
Heart Trouble					
High Blood Pressure					
Insomnia					
Kidney Trouble					
Liver trouble					
Migraines					
Nervousness/Anxiety					
Neuritis/nerve inflammation					
Neuralgia/pain along nerves					
Pinched Nerve					
Sciatica					
Scoliosis					
Stomach Trouble					
Other:					

If any of the above family members are deceased, please list their age at death and cause:

_____

_____

_____