



Olympic Chiropractic Welcomes YOU!

When a person seeks the services of a chiropractor, it is essential that they fully understand the objectives of that particular chiropractor.

We have one goal at Olympic Chiropractic; to restore and maintain the integrity of the spinal cord and its nerve roots. These vital nerve pathways are located in and protected by the bones of the spine. Misalignments of the vertebrae (bones of the spine), which interfere with the function of these nerve pathways, are called vertebral subluxations. Subluxations are caused by many of the things you do everyday and keep your whole body from functioning properly. It is our absolute conviction that the body is always better off without this interference.

Consequently, the objective of Olympic Chiropractic is to provide a chiropractic adjustment to correct subluxations thereby restoring normal nerve function. It is not the objective or intention of this office to fix, treat or attempt to cure any physical, mental or emotional ailment or to give advice about any ailments. With a proper nerve supply your whole body is better able to reach its full potential and to express more life.

The information we receive from you is important. We ask only that which is necessary for your care here. Please fill out the forms completely and to the best of your ability. If you have any questions or if there is any information you feel we should know, please let us know.

I, (we) _____, have read the above, understand it fully and choose to receive chiropractic for myself and for my family members listed below.

Signature

Date

PATIENT INFORMATION SHEET

PATIENT:

Last Name _____ First Name _____ Middle _____

Gender M F Date of Birth ___/___/___ Age _____ S S # _____

Home Address _____

City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____

Employer Name _____ Occupation _____

Employer Address _____

City _____ State _____ Zip _____

SPOUSE or GUARDIAN:

Last Name _____ First Name _____ Middle _____

Employer Name _____

Work Phone # _____ Date of Birth ___/___/___ S S # _____

EMERGENCY: Name and address of nearest relative or friend not living with you

Last Name _____ First Name _____ Relationship _____

Home Phone# _____ Work Phone# _____

Cell Phone _____

ABOUT YOU

E-Mail: _____

Number of children: _____

Hobbies and Interests:

Children's names and ages:

Have you been to a chiropractor before? Y ___ N ___

Who and when _____

Have you seen an MD within the last year? Y ___ N ___ If yes, please

explain: _____

What brings you to the office today?

If you have no specific problem but are here to have your spine checked for vertebral subluxation, check here: _____

List any surgeries, falls, accidents or injuries, including complications during or after your own birth

WOMEN: Is there a possibility you are pregnant? Y ___ N ___

Current Medications: _____

Vitamins: _____

Last time you saw the dentist? _____

Optometrist? _____

What exercises do you perform? _____

Frequency _____

Was your birth: c-section _____ vacume _____ forceps _____

Were you vaccinated: _____ Y ___ N Breat-fed: _____ Y ___ N Abused: _____ Y ___ N

How old is your mattress? _____

Please circle the following conditions you may have had or have now or are in your family if known:

Alcoholism	Convulsions	Heart Attack	Miscarriage
Allergy	Depression	Heart Disease	Neck Pain
Anemia	Diarrhea	High Blood Pressure	Polio
Arthritis	Diabetes	Hypoglycemia	Sinus Trouble
Back Aches	Epilepsy	Measles	Stroke
Cancer	Gall Bladder	Menstrual Irregularity	Ulcers
Cold Sores	Gout	Migraine	Constipation
Vascular Disease	Multiple Sclerosis	Headaches	

Other: _____

What do you do for fun? _____

How are your activities hampered by your present health status if any? _____

What activities do you envision doing when you retire? _____

Who would you like to be doing these activities with? _____

ON A SCALE OF 1-10:

How committed are you to maximizing your health potential? _____

How committed are you to maximizing the health potential of your family? _____

What if any spinal maintenance programs have you been given in the past? _____

Did you follow them? _____

Basic Fee Schedule

Consultation	No Charge
Standard Examination	\$95
Re-Examination/Progress Check	\$25-\$70
Spinal Adjustment	\$55-\$80
Spinal Intersegmental Traction	\$20
Spinal Xrays	
Cervical	\$30 Each
Lumbar	\$45 Each
Full Spine	\$180
Nutritional Consultation	\$100

INQUIRE ABOUT OUR UNLIMITED CARE AT A

TO OUR INSURED PATIENTS: Different carriers have different coverages, therefore, you will be responsible for services rendered until the office has time to verify your benefits. After you have attended a doctors orientation we will discuss your coverage together along with your recommendations for care and discuss financial options in detail. It is our policy to bill your insurance carrier as a courtesy to you. Because insurance is an agreement between you and your insurance carrier, it is your responsibility to make sure that any and all correspondence be given to us. If your insurance balance becomes over 60 days past due you will be asked to pay the balance or assist in contacting the carrier.

TO OUR MEDICARE PATIENTS: Typically, 12 visits, maximum, are allowed per year. Medicare does not pay for examinations, xrays or physiotherapy. If you have secondary coverage, it will pay only that portion that medicare did not pay on services it allowed. Your secondary benefit will not cover those services medicare did not allow. You will be asked to sign a form acknowledging understanding of this information.

PAYMENT OF BILLS: We expect you to honor your financial arrangements with our office. If you find that you cannot fulfill the agreement that you have made, advise us so new arrangements can be made. Our policy is not to allow patient balances to exceed \$250; insurance balances may exceed this limit. You will be asked to give the office a credit card number, if you have one, to keep on file should your balance become overdue or exceeds the limit. If you have any questions at any time about our financial policies, please ask! **Remember, we are here to serve you.**

Olympic Chiropractic Office...11545 Olympic Blvd. L.A., CA 90064...310.477.4531 fax 310.477.2443

PAYMENT POLICIES

1. PAYMENT FOR YOUR FIRST DAY'S SERVICES IS DUE AT THE COMPLETION OF YOUR OFFICE VISIT.
2. SIGNATURE BELOW ACKNOWLEDGES THAT IF YOUR PERSONAL BALANCE EXCEEDS \$250.00, YOUR CREDIT CARD (LISTED BELOW) WILL AUTOMATICALLY BE CHARGED THE FULL AMOUNT DUE. _____initial

ASSIGNMENT & RELEASE

I authorize release of information to family, physicians, employer and insurance companies.

I authorize the taking of photographs and x-rays to be used for treatment purposes.

I authorize the performance of other diagnostic and therapeutic procedures for treatment purposes.

I authorize my insurance benefits (if any) to be paid directly to:

OLYMPIC CHIROPRACTIC/DR. GLENN FISCHER
11545 Olympic Blvd.
Los Angeles, CA 90064

I acknowledge that I am financially responsible for non-covered services. I also understand that if I terminate my care any fees for professional services rendered me will be **immediately** due and payable.

Patient's
Signature: _____ Date: _____

Guardian's
Signature: _____ Date: _____

Bank: _____ Branch: _____

AMEX VISA DISCOVER M/C

Credit Card#: _____ Exp: _____