Welcome to our office!

Castellucci Chiropractic Center

271 Old Barn Rd, Hendersonville NC 28791 828-890-8181

Family Chiropractic Care

Name _____ Date _____

Address _____ City _____ Zip _____

Home # _____ Work # _____ e-mail _____

Occupation _____ Employer _____

Date of Birth _____ Age _____ S/M/D/W Spouse's Name _____

Previous Chiropractic care? Y / N Reason _____

What brings you to our office? _____

Who can we thank for telling you about us? _____

You were born to be healthy all of your life. Good health depends upon everything in your body being connected to your brain by nerves that pass between the bones of your spine. A subluxation is a disconnection between your brain and body affecting your health. Chiropractic restores this connection.

Please describe your current condition:

Tell us about any injuries or traumas you have had:

Tell us about any hospitalizations or surgeries you have had:

What drugs, if any, are you taking?

Tell us about any other current or past health conditions and are you seeing your MD for these?

Have you ever fractured your spine? Y/N _____ Any other bones? Y/N

As a result of my chiropractic care, I would like to: *(please check all that apply)*

❒ Feel better quickly ❒ Have a healthier spine ❒ Live a healthier lifestyle

Signature: Date:

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Insurance Information

Patients Name _____ Date of Birth _____

Employer _____

Insurance Company _____

Insurance Co. Address _____

Insurance Co. Telephone _____

Policy # _____ Group # _____

Medicare Information

Medicare # _____

Supplemental Insurance Information _____

Assignment & Authorization

I hereby assign and authorize payments of benefits to Dr. Ron R. Castellucci, Chiropractor for professional services rendered by Dr. Castellucci. In consideration of this assignment, Dr. Castellucci extends partial credit.

I authorize Dr. Castellucci and/or Castellucci Chiropractic Center to release any information to any insurance company, adjuster or attorney pertaining to this case, that will assist in the payment of a claim.

I fully understand and agree that my insurance policy is an arrangement between my insurance carrier and myself. I understand that I will be responsible for any expenses that the insurance carrier does not cover. I agree that a photocopy of this document will be as valid as the original.

Signed: _____ Date: _____
Patient (or guardian if minor)

Terms of Acceptance

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When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the gentle, specific application of force to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease, infirmity or symptoms.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

- ☐ I have read and fully understand the above statements.
- ☐ I therefore accept chiropractic care on this basis.

Signed: _____ Date: _____
Patient (or guardian if minor)

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Consent for Use or Disclosure of Health Information

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before your sign this consent form (164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing, when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information., please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

Printed Name _____

Signature _____ Date _____

Patient (or guardian if minor)