Andres Galego, D.C.
ABH CHIROPRACTIC
"American Back Health"

Patient #:______________

PATIENT INFORMATION

Name:_______________ Age:_____ Birthdate: _______________
Address:_______________ City/State/zip:_______________
Social Security#:_______________ Home phone#:_______________ Cell#:_______________
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Male ☐ Female
Work:_______________ Occupation:_______________
Work Address:_______________ Work#_______________
Best time and place to reach you:_______________ email: _______________
Spouse's Name:_______________ Birthdate: _______________ SS#_______________
Emergency Contact: Name: _______________ Home#_______________
Work# _______________ Cell# _______________
Who may we thank for referring you? _______________

Date of Injury/Accident:_______________ Emergency Treatment Rendered? ☐ YES ☐ NO
If YES, when and where? _______________
Were X-rays taken for this problem? ☐ YES ☐ NO Are you Pregnant? yes ☐ or no ☐

HEALTH INSURANCE

Insurance Co:_______________ ID#_______________ GROUP#_______________
Subscriber's name:_______________ ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

WORKER'S COMP

Insurance Co:_______________ ID#_______________ GROUP#_______________
Employer:_______________ Claim#_______________
Contact Person:_______________ Contact Number:_______________
Was Injury Reported? ☐ YES ☐ NO Place of Injury:_______________
Have you missed time from work? ☐ YES ☐ NO If YES, give dates:_______________

PERSONAL INJURY

☐ Auto ☐ Driver ☐ Passenger Place of Accident: ☐ MD ☐ VA ☐ DC ☐ Other_________
Your Auto Ins:_______________ PIP Filed? ☐ YES ☐ NO
Policy Holder:_______________ Claim#_______________
Legal Case? ☐ YES ☐ NO Attorney:_______________ Phone#:_______________
Address:_______________

Other Payment Method: ☐ CASH ☐ CHECK ☐ CREDIT CARD Visa( ) Master Card( ) Discover( )

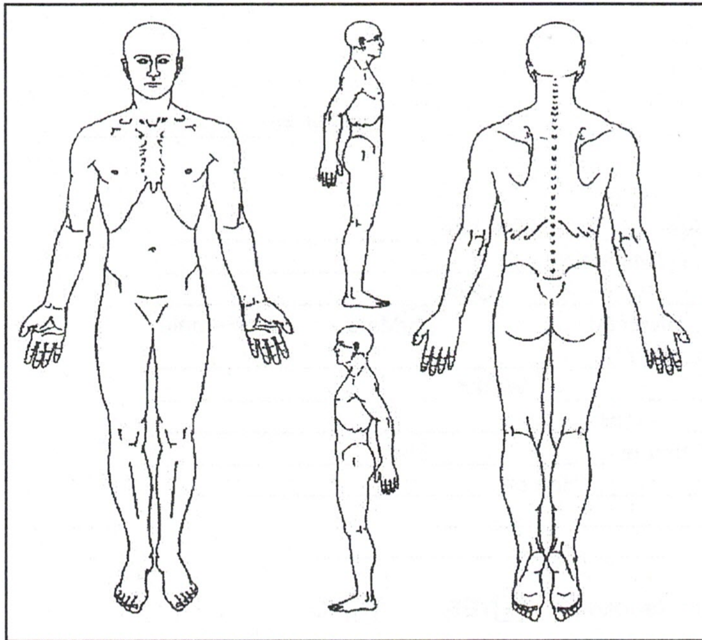
Name on Card:_______________ Account#_______________ EXP:_______ CVC:_______
All accounts not paid within 45 days of service will automatically be put through on your credit card unless other arrangements have been made with this office. I authorize this office to charge any past due balance on my credit card.

Signature: X_______________ Date:_______________

I, the undersigned certify that I (or my dependent) have insurance coverage with_______________
And assign directly to Dr. Andres Galego, D.C. (ABH Chiropractic) all insurance benefits for services rendered. I certify that the information I have reported with regards to my insurance coverage is correct. I understand and agree that all services rendered to me are charged directly to me and that I am responsible for all charges whether or not paid by insurance. I authorize Dr. Andres Galego, D.C. (ABH Chiropractic) to release any information necessary to secure the payment of benefits.

Signature of Subscriber or Beneficiary: X_______________ Date:_______________

Place an **X** on the picture where you continue to have discomfort.



Have you ever suffered from:

1. Dizziness Yes___ No___
2. Headaches/Migraines Yes___ No___
3. Heart Troubles Yes___ No___
4. Diabetes Yes___ No___
5. Arthritis Yes___ No___
6. Backaches Yes___ No___
7. Asthma Yes___ No___
8. Neuritis Yes___ No___
9. Digestive Disorder Yes___ No___
10. Nervousness Yes___ No___
11. Sinus Trouble Yes___ No___
12. Neck Pain Yes___ No___
13. Muscle cramps Yes___ No___
14. Clumsiness Yes___ No___
15. Loss of sleep Yes___ No___
16. Ringing in the ears Yes___ No___
17. Difficulty swallowing Yes___ No___

Patient's Signature : X ____________________

Health Information

What is your primary concern or symptom? ____________________

When did this happen or start? ____________________

How often does it occur? ____________________

Describe the type of pain or discomfort (dull, sharp,tingling etc): ____________________

What makes it feel better? ____________________

What makes it feel worse? ____________________

What is your secondary concern or symptom (if any)? ____________________

When did this happen or start? ____________________

Describe the type of pain or discomfort (dull, sharp,tingling etc): ____________________

What makes it feel better? ____________________

What makes it feel worse? ____________________

Is this condition interfering with your; Work___ School___ Sleep___ Daily Routine___ Recreation___ Other __________

Past Injuries: (including childhood) list major injuries; car/bicycle accidents, any traumas, dates and related symptoms:

____

Have you recently consulted a physician or any other healthcare professional for this condition? ( ) Yes ( ) No

If so, please provide name and specialty____________________

Hospitalization & Surgeries- List all hospitalization and surgeries, (performed or suggested), dates and any current related symptoms. *Please notify us of any pins, wires, prosthesis, canes or any other special equipment* __________

____

Medication/Supplements (dosage and condition treated):____________________

Allergies? Yes____ No____ (if yes, please list) ____________________

Have you had any X-Rays, CAT scans, MRI's, Blood work done for this issue? ( )Yes ( )No

What were the results? ____________________

Thank you for choosing our office!

We look forward to helping you achieve greater health and wellness.

Authorization to Pay Physician

I hereby authorize the ____________________, Insurance Company to pay by check made payable and mailed directly to:

Name: Dr. Andres Galego D.C. ABH Chiropractic
Address: 12301 Old Columbia Pike, Suite 106
Silver Spring, MD 20904

The medical and surgical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. I hereby designate Dr. Andres Galego,D.C. ABH Chiropractic, as a third party beneficiary to the PIP coverage, med pay, or any other first party benefits that I may be entitled to under the insurance policy with the above name and insurance company. It is my intention that Dr. Andres Galego, D.C. ABH Chiropractic as a third part beneficiary, has the same rights as I would to institute legal proceedings or take other actions to enforce the insurance contract. This payment will not exceed my indebtedness to the above mentioned assignee, and I agree to pay, in a current manner, any balance of said professional Delinquent payment of my balance will be charged at 1.5% monthly interest rate.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

A photocopy of this assignment shall be considered as an effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Date: ____________________

____
Signature of Policy Holder

X________________________________(Seal)
Signature of Claimant

____
Print Name

Authorization and Assignment

Andres Galego, D.C.
ABH Chiropractic
"American Back Health"
12301 Old Columbia Pike, Suite 106 Silver Spring MD 20904
(301) 625-0050 Fax: (301) 625-0054

Patient Name ______________________________ Acct No. ____________________

I hearby authorize, Andres Galego, D.C. P.C. to furnish my attorney named below, copies of medical records requested in reference to all illness and injuries sustained by me, my child, or children including (but not limited to) the injuries which were sustained on ____________________.

I further in exchange for furnishing the reports, irrevocably assign to you, and authorize and direct said attorney(s) to pay to you from the proceeds of any recovery including reports, conferences, preparation for testimony, depositions and court testimony as an expert witness whether such proceeds are recovered as a result of compromise, collection of judgment of monies received from PIP, med pay, no fault or any other insurance policy.

I understand that payment for services is not contingent upon recovery and that this does not relieve me of my personal, primal obligation to pay for the services when rendered. If Collections is necessary, I will be responsible for attorney fees, and collection expenses in addition to doctor bills.

I also understand that I will be responsible for payment of services rendered in the event that my attorney no longer represents me or, I dismiss my attorney. Should I dismiss my attorney or lose my case, payment of dates unpaid will be due immediately at the rate of a Cash/ Non Insurance patient. Delinquent payment of my balance will result in 1.5% monthly interest fee of the original full balance.

I hereby agree to waive the defense of Statue of Limitations as it pertains to any claim filed against me beyond three years (or other statutory period) after services were rendered. I also understand that my balance remaining after three years will be charged a 1.5% monthly Interest. This agreement will be subject and governed by the laws of the state of Maryland, that the patient and undersigned attorney shall waive all rights to discharge this debt through bankruptcy.

(SEAL) Signature X ______________________________ Date ____________________

The undersigned attorney or Insurance company agree to:

1. Comply fully with the above Authorization and Assignment. In the event that ABH Chiropractic, their agent and or 3rd party have to file legal action to collect this debt, the patient and signed attorney agree to pay for any and all attorney and collections fees to enforce and collect the outstanding lien amount.

2. Withhold any pay from my proceeds from settlement collection of judgment, PIP, med pay, no fault or other insurance proceeds the amount of the doctor's charges after contracting the billing office for a current balance.
3. Advise within ten days of the doctor's status request of status of the above reference claim.
4. Notify the doctor immediately of any change in status of claim, which may preclude payment of the doctor's charges.
5. To require any attorney to whom the undersigned refers this case, within or outside the firm, to honor this assignment as a condition of referral.
6. To furnish home and work address information about the patient or family to aid collection of this bill.

____

Signature of Attorney Name of Attorney Date

____

Firm Name Address Telephone

Please date, sign and return one copy to the doctor's office at once.

OFFICE POLICY

Andres Galego, D.C.
ABH Chiropractics
"American Back Health"
12301 Old Columbia Pike, Suite # 106 Silver Spring MD 20904

We believe that a clear definition of our office policies will allow both you, the patient, and us the doctor, to concentrate on the big issue--- REGAINING AND MAINTAING YOUR HEALTH.

APPOINTMENT POLICY
Multiple appointments have been scheduled, for your convenience, to minimize waiting and to facilitate visits that counts and not the days.

If you are unable to keep an appointment for any reason, we require that you call immediately to reschedule your visit. It is your obligation to make up a missed appointment within seven days of any cancellation.

This office reserve the right to charge for missed appointments and those cancelled without 24 hours notice.

When entering the office on any given visit, please go directly to the front desk "sign-in". We attempt to honor all appointments at the scheduled time. If you are late, you may have to wait for the next available appointment. If you have any questions regarding our office policy or your appointment, please do not hesitate to speak to the receptionist directly.

FINANCIAL POLICY
1. It is our office policy that all services rendered in this office are charged directly to you, the patient, and that you are personally responsible for all payments, regardless of whether or not this office accepts insurance assignment. This agreement will be subjected and governed by laws of the state of Maryland, that the patient shall waive all right to discharge this debt through bankruptcy.

2. All cash payments are expected at the time of service or at the end of each week. Patient's balances may not exceed $200.00 at any time.

3. All insurance assignment patients must pay their deductible in full and the co-insurance at the time of service or at the end of each week. Insurance assignment patient's balances may not exceed $200.00 at any time.

4. If you lose your case and/or choose to leave your lawyer, YOU are responsible for your balance.

5. Returned checks and balances over 30 days from service may be subject to additional collection fees.

6. All accounts not paid within 90 days will automatically be put through on your personal credit card.

Type: Visa or MasterCard (please circle one)

Account # ________________________ Exp. Date: ________________

Patient's signature: X________________________ Date: ________________

Patient's address: ____

Home Phone #: ________________ Work Phone #: ________________

Informed Consent
Chiropractic Adjustment
And Care Form

Last Name:	**First Name:**

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.
Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.
Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.
Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightening. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.
Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor. Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.
Treatment Results: I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.
Alternative Treatments Available: Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.
Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.
Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy.
Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.
Surgery: Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.
Non-treatment: I understand the potential risks of refusing or neglecting care may include increases pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment, physical therapy and exercises. I intend this consent to apply to all my present and future chiropractic care.

Signature of Patient:	**Signature of Witness:**	**Date and Time:**
X		

Andres Galego, D.C.
ABH CHIROPRACTIC
"American Back Health"
Chiropractor/Sports Injury specialist
12301 Old Columbia Pike, Suite 106
Silver Spring, MD 20904
(301)625-0050
7676 New Hampshire: Ave, suite 402
Langley Park, MD 20912

Use and Disclosure of protected health information
Patient Acknowledgement and Consent Form

Acknowledgment of Notification

The educational pamphlet entitled "Notice of Privacy Practices" provides information about how Dr. Andres Galego, D.C. may use and disclose protected health information about you, and is compliant with the requirements in the health insurance Portability and Accountability Act of 1996(HIPPA).

Our Notice of Privacy practices states that we reserve the right to change the terms described. Should this happen, you will be notified on your next visit to our office.

You have the right to request restriction on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions: but if we do, we are bound by our agreement with you.

By signing below, you acknowledge receipt of our Notice of Privacy Practices.

X____

Consent for use and Disclosure of information

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosure and trust on your prior consent.

I request that payment of authorized medical Insurance Carrier benefits be made on my behalf to ANDRES GALEGO, D.C. for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me release to the centers for any Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my Insurance Carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreement.

X______________________________________

____

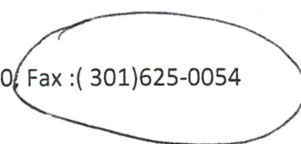
Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name______________________________
(please print)

Signature X______________________________
Birthdate______________________________
Date______________________________

ABH Chiropractic
"American Back Health"
Dr. Andres Galego, D.C.
12301 Old Columbia Pike Silver Spring, MD 20904--- Telephone: (301) 625-0050, Fax :(301)625-0054
7676 New Hampshire Ave., Suite 404
Takoma Park, MD 20912 --- Telephone (301) 439-4440, Fax: (301)439-4448
www.abhchiropractic.com



Release Of Medical Records

I ______________________________ hereby grant permission to disclose and/or release all information and records regarding my treatment, diagnostic reports, X-Ray reports and consulting reports.

Please send copies of my records to fax # (301) 625-0054

Date: ____________________________

Signature: ____________________________

Witness: ____________________________

ABH Chiropractic
"American Back Health"
Dr. Andres Galego, D.C.
12301 Old Columbia Pike Silver Spring, MD 20904--- Telephone: (301) 625-0050
7676 New Hampshire Ave., Suite 404
Takoma Park, MD 20912 --- Telephone (301) 439-4440
www.abhchiropractic.com

Date: ________________

PERMISSION TO GIVE MEDICAL INFO TO PARENTS/SPOUSE/GUARDIAN

I ________________________________ am over the age of 18 and I give permission for ABH Chiropractic, and/or their staff to release medical, financial and/or insurance information to my PARENTS/SPOUSE/GUARDIAN (circle one), ________________________________ (Full name of person to receive information), in my presence or not.

Patient Signature: X ____

Patient Name: ____

Phone: ____