New Practice Member Packet

Patient Name: _____

Appointment Date & Time: _____

Welcome to Via Vitae Chiropractic! Attached you will find the necessary forms to **COMPLETE** and **BRING WITH YOU** to your scheduled appointment. As a courtesy to our practice members, we do verify health insurance benefits; please bring both a government ID and an insurance card to your first appointment for this benefits check. In the event that you have eligible chiropractic benefits, we will inform you of what they are but keep in mind this is not a guarantee of coverage.

*****In preparation for your first appointment, please do not ingest any *caffeine, sugar, medications (except insulin), or nicotine* at least two (2) hours before your appointment, if possible. These chemicals can alter the scan of your nervous system that will be performed, making it less accurate.*****

In the event that you are not able to keep your new appointment time, we require a minimum of a 24-hour notice of schedule changes. Please call our office as soon as possible with any schedule change so that we may reschedule your appointment as a courtesy to other patients who may be waiting for an appointment.

We thank you for your cooperation and look forward to serving you and your family. If you have any further questions, please contact our office.

Yours in Health,
Dr. Babin and Staff

Contact Us:

(757) 208-7108
info@viavitaechiropractic.com
www.ViaVitaeChiropractic.com
4511 John Tyler Hwy. Suite B Williamsburg, VA 23185

Confidential Member Information - Health Review

Name: _____ Birth Date: ____/____/____ Age: _____ ☐M ☐F

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Cell Phone Provider: _____

Home Phone: _____ Cell: _____ Work: _____

Would you like to receive SMS text reminders for your scheduled appointments? ☐ ***Yes*** ☐ ***No***

Marital Status: ☐Single ☐Married SSN#: _____ Driver's License #: _____

Employer: _____ Occupation: _____ Years at Job: _____

Spouse's Name: _____ Spouse's Employer: _____

Previous Chiropractic Care? ☐Yes ☐No *If yes,* when? _____ Where? _____

Who may we thank for referring you to our office? _____

Number of Children and Ages: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: *Primary*: _____

Secondary: _____ *Third*: _____ *Fourth*: _____

On a scale of 0 to 10 with *zero being no pain* and *10 being the worst*, rate your above complaints (circle one).

Primary or chief complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10	_____
Secondary complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10	_____
Third complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10	_____
Fourth complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10	_____

If completing online, please fill in your answer to the left on the corresponding line instead of circling your answer.

When did the problem(s) begin? _____ When is the problem at its worst? ☐AM ☐Mid-day ☐PM

How long does it last? ☐Constant **OR** ☐Off & On During Day **OR** ☐Comes & goes throughout the week

Condition(s) treated by anyone in the past? ☐Yes ☐No *If yes,* when? _____ Doctor: _____

How long were you under care? _____ What were the results? _____

PLEASE MARK the areas *on the diagram below in the corner* with the following letters to describe your symptoms:
R=**R**adiating **B**=**B**urning **D**=**D**ull **A**=**A**ching **N**=**N**umbness **S**=**S**harp/**S**tabbing **T**=**T**ingling

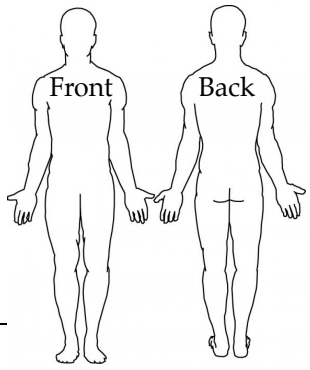
What relieves your symptoms? _____

What makes them feel worse? _____

Does your pain travel anywhere? _____

Is your condition the result of ANY type of accident/injury? ☐Yes ☐No

If Yes, How did the injury happen? _____



Confidential Member Information - Health Review

Identify any other injury(ies) to your spine, minor or major, including ***all*** **motor vehicle accidents**:

_____

_____

PAST HISTORY

Have you experienced these problems or a similar problem in the past? ☐ Yes ☐ No *If yes*, explain: _____

_____

When was the last episode? _____ How did the episode happen? _____

Other forms of treatment performed? ☐ Yes ☐ No *If yes*, explain: _____

Treatment provider: _____ When? _____ Results: ☐ Favorable ☐ Unfavorable

Explain results: _____

Please list all past jobs that imposed physical stress on your body: _____

If you have ever been diagnosed with any of the following conditions, please indicate a **P** for in the **Past**, a **C** for **Currently** have, or an **N** for **Never** have had**:**

___Broken Bone ___Dislocations ___Tumors ___Rheumatoid Arthritis ___Diabetes ___Disability ___Cancer

___Heart Attack ___Osteoarthritis ___Cerebral Vascular ___Other serious conditions:_____

_____

Please identify ALL PAST and CURRENT conditions:

All Surgeries	How long ago?	Inpatient or Outpatient?	By whom?
1			
2			
3			

Childhood Diseases	How long ago?	Inpatient or Outpatient?	By whom?
1			
2			
3			

Adult Diseases	How long ago?	Inpatient or Outpatient?	By whom?
1			
2			
3			

Confidential Member Information - Activities of Life

Please mark below: **P** for **P**ast, **C** for **C**urrently Have, and **N** for **N**ever Have Had on each line.

__ Headaches	__ Pregnant	__ Hepatitis: A B C	__ Prostate Problems	__ Ulcers
__ Migraines	__ Frequent Colds/Flu	__ Loss of Balance	__ Impotence/Sexual Dysfun.	__ Heartburn
__ Neck Pain	__ Seizures/Epilepsy	__ Fainting	__ Digestive Problems	__ Foot Problems
__ Shoulder Pain	__ Ear Fullness	__ Low Blood Pressure	__ High Blood Pressure	__ Knee Problems
__ Upper Back Pain	__ Chest Pain	__ Blurred Vision	__ Diarrhea/Constipation	__ Double Vision
__ Mid Back Pain	__ Pain w Cough/Sneeze	__ Ringing in Ears	__ Menopausal Problems	__ Asthma
__ Low Back Pain	__ Dizziness	__ Hearing Loss	__ Menstrual Problem/PMS	__ Colon Issues
__ Hip Pain	__ Difficulty Breathing	__ Depression	__ Sinus/Drainage Problem	__ Lung Problems
__ Back Curvature	__ Bed Wetting	__ Kidney Problems	__ Swollen/Painful Joints	__ Irritability
__ Scoliosis	__ Learning Disability	__ Skin Problems	__ Gall Bladder Problems	__ Mood Changes
__ ADD/ADHD	__ Trouble Sleeping	__ Eating Disorder	__ Thyroid Dysfunction	__ Liver Problems
__ Jaw Pain/TMJ	__ Vertigo	__ Nausea/Vomiting	__ Heart Disease/Dysfunction	__ Allergies

__Numbness/Tingling **(Please check all that apply)**: ☐ Arms ☐ Hands ☐ Legs ☐ Feet ☐ Other:_____

MEDICATIONS & ALLERGIES

Are you currently taking any medications (prescription or non-prescription)? ☐ ***Yes*** ☐ ***No***

If yes, please list all **and** reason for medication: _____

_____

All known allergies:_____

SOCIAL HISTORY

➢**Smoking:** ☐ *Cigars* ☐ *Pipe* ☐ *Cigarettes* **Used**: ☐ *Daily* ☐ *Weekends* ☐ *Occasionally* ☐ *Never* ☐ *Quit*

➢**Alcoholic Beverage Consumption:** ☐ *Daily* ☐ *Weekends* ☐ *Occasionally* ☐ *Never*

➢**Recreational Drug Use:** ☐ *Daily* ☐ *Weekends* ☐ *Occasionally* ☐ *Never*

How does your condition affect the following? Please describe.

Hobbies: _____

Recreational Activities: _____

Exercise Regimen: _____

Confidential Member Information - Activities of Life

Please identify how your current condition is affecting your ability to perform daily routine activities.

ACTIVITIES:	***EFFECT:***			
Carrying groceries	☐ *No Effect*	☐ *Painful (can do)*	☐ *Painful (limits)*	☐ *Unable to Perform*
Sit to Stand	☐ *No Effect*	☐ *Painful (can do)*	☐ *Painful (limits)*	☐ *Unable to Perform*
Climbing Stairs	☐ *No Effect*	☐ *Painful (can do)*	☐ *Painful (limits)*	☐ *Unable to Perform*
Pet Care	☐ *No Effect*	☐ *Painful (can do)*	☐ *Painful (limits)*	☐ *Unable to Perform*
Extended Computer Use	☐ *No Effect*	☐ *Painful (can do)*	☐ *Painful (limits)*	☐ *Unable to Perform*
Household Chores	☐ *No Effect*	☐ *Painful (can do)*	☐ *Painful (limits)*	☐ *Unable to Perform*
Lifting/Carrying Children	☐ *No Effect*	☐ *Painful (can do)*	☐ *Painful (limits)*	☐ *Unable to Perform*
Reading	☐ *No Effect*	☐ *Painful (can do)*	☐ *Painful (limits)*	☐ *Unable to Perform*
Bathing	☐ *No Effect*	☐ *Painful (can do)*	☐ *Painful (limits)*	☐ *Unable to Perform*
Dressing	☐ *No Effect*	☐ *Painful (can do)*	☐ *Painful (limits)*	☐ *Unable to Perform*
Shaving	☐ *No Effect*	☐ *Painful (can do)*	☐ *Painful (limits)*	☐ *Unable to Perform*
Sexual Activities	☐ *No Effect*	☐ *Painful (can do)*	☐ *Painful (limits)*	☐ *Unable to Perform*
Sleeping	☐ *No Effect*	☐ *Painful (can do)*	☐ *Painful (limits)*	☐ *Unable to Perform*
Sitting	☐ *No Effect*	☐ *Painful (can do)*	☐ *Painful (limits)*	☐ *Unable to Perform*
Standing	☐ *No Effect*	☐ *Painful (can do)*	☐ *Painful (limits)*	☐ *Unable to Perform*
Yard Work	☐ *No Effect*	☐ *Painful (can do)*	☐ *Painful (limits)*	☐ *Unable to Perform*
Walking	☐ *No Effect*	☐ *Painful (can do)*	☐ *Painful (limits)*	☐ *Unable to Perform*
Sweeping/Vacuuming	☐ *No Effect*	☐ *Painful (can do)*	☐ *Painful (limits)*	☐ *Unable to Perform*
Dishes	☐ *No Effect*	☐ *Painful (can do)*	☐ *Painful (limits)*	☐ *Unable to Perform*
Laundry	☐ *No Effect*	☐ *Painful (can do)*	☐ *Painful (limits)*	☐ *Unable to Perform*
Taking Care of Garbage	☐ *No Effect*	☐ *Painful (can do)*	☐ *Painful (limits)*	☐ *Unable to Perform*
Driving	☐ *No Effect*	☐ *Painful (can do)*	☐ *Painful (limits)*	☐ *Unable to Perform*
Concentration	☐ *No Effect*	☐ *Painful (can do)*	☐ *Painful (limits)*	☐ *Unable to Perform*
Other: _____	☐ *No Effect*	☐ *Painful (can do)*	☐ *Painful (limits)*	☐ *Unable to Perform*

Patient Signature: _____ **Date:** ____/____/____

4511 John Tyler Hwy. Suite B Williamsburg, VA 23185 Reviewed by Brandon T. Babin, D.C. _____

Confidential Member Information - Family Health History

This form is to assist the doctor by providing past health history information for their review.

_____ _____

Print Patient Name Date

Does anyone in your family suffer with your condition(s)? ☐ Yes ☐ No

If yes, whom? ☐ Grandmother ☐ Grandfather ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Son(s) ☐ Daughter(s)

Have they ever been treated for their condition? ☐ Yes ☐ No ☐ I don't know

Any other hereditary conditions we should be aware of? ☐ Yes: _____ ☐ No

******Please place a check mark in the boxes below that apply to your family******

Conditions	Mother	Father	Daughter	Son	Spouse
Arm Pain					
Arthritis					
Asthma					
ADD / ADHD					
Allergies					
Back Pain					
Bed Wetting					
Cancer (Which type?)					
Cardiovascular Disease					
Carpal Tunnel					
Deceased					
Diabetes					
Digestive Problems					
Disc Problems					
Ear Infections					
Fibromyalgia					
Headaches					
Heart Disease					
High Blood Pressure					
Hip Pain					
Leg Pain					
Menstrual Disorder					
Migraines					
Neck Pain					
Scoliosis					
Shoulder Pain					
Sinus Trouble					
Other					

Confidential Member Information

QUADRUPLE VISUAL ANALOG SCALE

Patient Name: _____ **Date:** ____/____/____

PLEASE READ INSTRUCTIONS CAREFULLY:

Circle the number that best describes each question being asked. Please note: *If you have more than one complaint*, answer each question for *each individual complaint* and indicate the *score for each complaint*.

Please indicate your pain level right now, average pain, and pain at its best and worst.

EXAMPLE:

No Pain — Headache — Neck — Dizziness — *Worst Possible Pain*

0 1 (2) 3 4 (5) 6 7 (8) 9 10

---

1. How would you rate your pain or discomfort RIGHT NOW?

No Pain 0 1 2 3 4 5 6 7 8 9 10 *Worst Possible Pain*

2. What is your TYPICAL or AVERAGE pain or discomfort?

No Pain 0 1 2 3 4 5 6 7 8 9 10 *Worst Possible Pain*

3. Rate your pain or discomfort AT YOUR BEST (How close to "0" do you get at your best?).

No Pain 0 1 2 3 4 5 6 7 8 9 10 *Worst Possible Pain*

4. Rate your pain or discomfort AT YOUR WORST (How close to "10" do you get at your worst?).

No Pain 0 1 2 3 4 5 6 7 8 9 10 *Worst Possible Pain*

Reference: Thomeé R., Grimby G., Wright B.D., Linacre J.M. (1995) Rasch analysis of Visual Analog Scale. *Scandinavian Journal of Rehabilitation Medicine 27, 145-151.*

Other Comments:

Informed Consent

We encourage and support a **shared decision-making process** between us regarding your health needs. As a part of that process, you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you. We provide this information so you can make the decision of whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed so you can knowledgeably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health. A **vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly, causing interference and/or irritation to the nervous system. **Adjustments** are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by a vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct a vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered, but they are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility, and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment. **(Continued on next page)**

Patient Initials: _____

Informed Consent (Continued)

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Via Vitae Chiropractic, have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. Having this knowledge, I knowingly authorize chiropractic care with Via Vitae Chiropractic by any means, method, and or techniques the doctor deems necessary at any time throughout the entire clinical course of my care.

_____ ____/____/____ _____

Patient Signature (or Legal Guardian) **Date** **Office Staff Initials**

PARENTAL CONSENT FOR MINOR PATIENT ONLY

Name of Minor: _____ **Patient Age:** _____ **DOB:** ____/____/____

_____ _____ ____/____/____

Legal Guardian Name Printed Legal Guardian Signature Date

In addition, by signing below I give permission for the above named minor patient to be managed by the doctor, even when I am not present to observe such care. I also agree to be present for all progress evaluation appointments of the above named minor patient.

_____ _____ ____/____/____

Legal Guardian Name Printed Legal Guardian Signature Date

NON-PREGNANCY VERIFICATION - FEMALES ONLY

Females Only: *Please read carefully and include the appropriate date, check ✓ the correct box, then sign below if you understand and have no further questions. Otherwise, please see receptionist for further explanation.*

The first day of my last menstrual cycle was on ____/____/____.

☐ I hereby notify all concerned that I neither suspect nor know positively at this time that I may be pregnant. I release this clinic and all damages arising from any and all procedures of diagnostic x-rays or care nature with reference to the possibility of pregnancy.

☐ I am currently pregnant and I am due on ____/____/____.

_____ ____/____/____ _____

Patient Signature (or Legal Guardian) **Today's Date** **Office Staff Initials**

Notice of Privacy Practice

This office is required to notify you in writing that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center or have copies made, we will be happy to accommodate you. However, you will be responsible for the cost per Virginia's state law.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Brandon Babin at (757) 208-7108. If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Notice of Privacy Practice Continued

I read the Privacy Practice Notice and I understand that I may retain the previous page if desired.

***Patient Initials** (or Legal Guardian):* _____

I have received a copy of VIA VITAE CHIROPRACTIC'S Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____/_____/_____

Patient Name Printed Patient's DOB

_____ _____/_____/_____

Patient Signature (or Legal Guardian) Date

_____

Office Staff Signature

Insurance Verification Form

Member Name: _____ Date of Birth: ____/____/____

Social Security Number: _____ Marital Status: _____

Insurance Company (Primary): _____ (Secondary): _____

Name of Insured *(if different)*: _____ Date of Birth: ____/____/____

Insured Social Security Number *(if different)*: _____

Do you have an HSA/FSA *(Health/Flexible Savings Account)*? ☐ Yes ☐ No

RELEASE OF AUTHORIZATION/ASSIGNMENT OF BENEFITS

I authorize and request payment of insurance benefits directly to Brandon T. Babin, D.C. or Via Vitae Chiropractic. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Patient Signature: _____ **Date:** ____/____/____

For Office Use Only

☐ Calendar ☐ Plan ☐ Benefit Spoke with: _____

Ref #: _____ Effective Date of Ins: _____ Date Verified: _____

Chiropractic Benefits (Out of Network):

Deductible: $_____ Amt. Met: $_____ Out of Pocket Max: $_____ Amt. Met: $_____

Co-Pay: $_____ Co-Ins: _____% Visits Covered: _____ Visits Used: _____

Notes: _____

Referral? **YES / NO** Pre-authorization: **YES / NO** _____

Chiropractic Benefits (In Network):

Deductible: $_____ Amt. Met: $_____ Out of Pocket Max: $_____ Amt. Met: $_____

Co-Pay: $_____ Co-Ins: _____% Visits Covered: _____ Visits Used: _____

Notes: _____

Referral? **YES / NO** Pre-authorization: **YES / NO** _____

Medical Information Release Form (HIPAA Release Form)

Patient Name: _____ DOB: _____

RELEASE OF INFORMATION

____ *Initial* I authorize the release of information including appointments, the diagnosis, records, and examination rendered to me as well as claims/billing information. This information may be released to the following people selected below *(check all that apply)*:

☐ *Spouse's Name:* _____

☐ *Children's Names:* _____

☐ *Other Names:* _____

☐ *Information is not to be released to anyone*

This Release of Information will remain in effect until terminated by me **in writing given to Via Vitae Chiropractic in person**.

MESSAGES

Please call: ☐ my **home** ☐ my **work** ☐ my **mobile** number: _____

If unable to reach me:

☐ You may leave a detailed message

☐ Please leave me a message asking me to return your call

☐ Other: _____

The best time to reach me is *(day)* _____ between *(times)* _____ & _____.

_____ ____/____/____

Patient Signature (or Legal Guardian) **Date**

_____

Office Staff Signature

Financial Agreement

Please read through each section carefully, then initial each section and sign below

____ I understand that if I *do not* pay my account in full with Via Vitae Chiropractic, my account may be assigned to a collection agency for collection.
Initial

____ I understand that if my account is assigned to a collection agency, the collection agency will charge a commission or fee that may be as much as 50% of the amount I owe to Via Vitae Chiropractic. I agree that if my account is assigned to a collection agency, Via Vitae Chiropractic may add the amount of the collection agency's commission or fee to the amount that I owe Via Vitae Chiropractic and I agree to pay that additional amount.
Initial

____ I understand and agree that in the event legal action is commenced to enforce my obligations hereunder, I will pay court costs and reasonable attorney's fees.
Initial

_____ _____/_____/_____

Patient Signature (or Legal Guardian) **Date**

_____

Office Staff Signature