



Welcome to The Grove Center for Chiropractic & Wellness, Inc.!

We want to make sure your visits to The Grove Center are pleasant, productive, and stress-free. We hope to make your experience at The Grove Center one that is positive and that will assist you in returning to your active lifestyle. The following is important information regarding your upcoming visits to our clinic.

Initial Visit

Your first visit will include a medical history, thorough evaluation and treatment, if time permits. The more complex the case, the more important the history and evaluation are in determining the proper course of treatment. Your doctor will provide you with helpful information regarding your condition and will outline a treatment plan so you will know what to expect during each follow up visit. A typical initial visit lasts one hour.

Follow up Visits

All subsequent visits are approximately 20-30 minutes in length. Please arrive **before your scheduled appointment time** so you are ready to go (changed, etc.). The doctors usually run on time so *if you expect to be late for your appointment, please call our office as we may have to reschedule your appointment*. Please wear (or bring with you) comfortable work out style clothing for each treatment. We do have shorts and tee shirts for your use if you forget to bring your own.

Homework!

You may be given exercises or stretches to perform on your own between visits. Your participation in improving your health is just as important as ours, so please do all exercises/stretchers as instructed.

Financial Information

When you check out at the end of each visit, payment for service is expected. Our clinic participates with Blue Cross Blue Shield PPO insurance plans only (Federal and Medicare plans are handled differently, please ask for more information). Your insurance plan may have a deductible and/or co-payments or co-insurance for which you are responsible. We will file BCBS and Medicare claims on your behalf. We will do our best to ascertain your level of coverage at our office **but ultimately it is your responsibility to understand your coverage**. To obtain information about your specific plan, we encourage you to contact your insurance company's customer service department.

Kirsten S. Grove, DC, CCSP
8130 Boone Boulevard, Suite 110
Vienna, VA 22182
703.760.8110
703.760.8111 (fax)
www.grovetwellness.com
FrontOffice@grovetwellness.com

The Grove Center for Chiropractic & Wellness, Inc.

Kirsten S. Grove, DC, CCSP
Certified Chiropractic Sports Physician

Patient Information Sheet

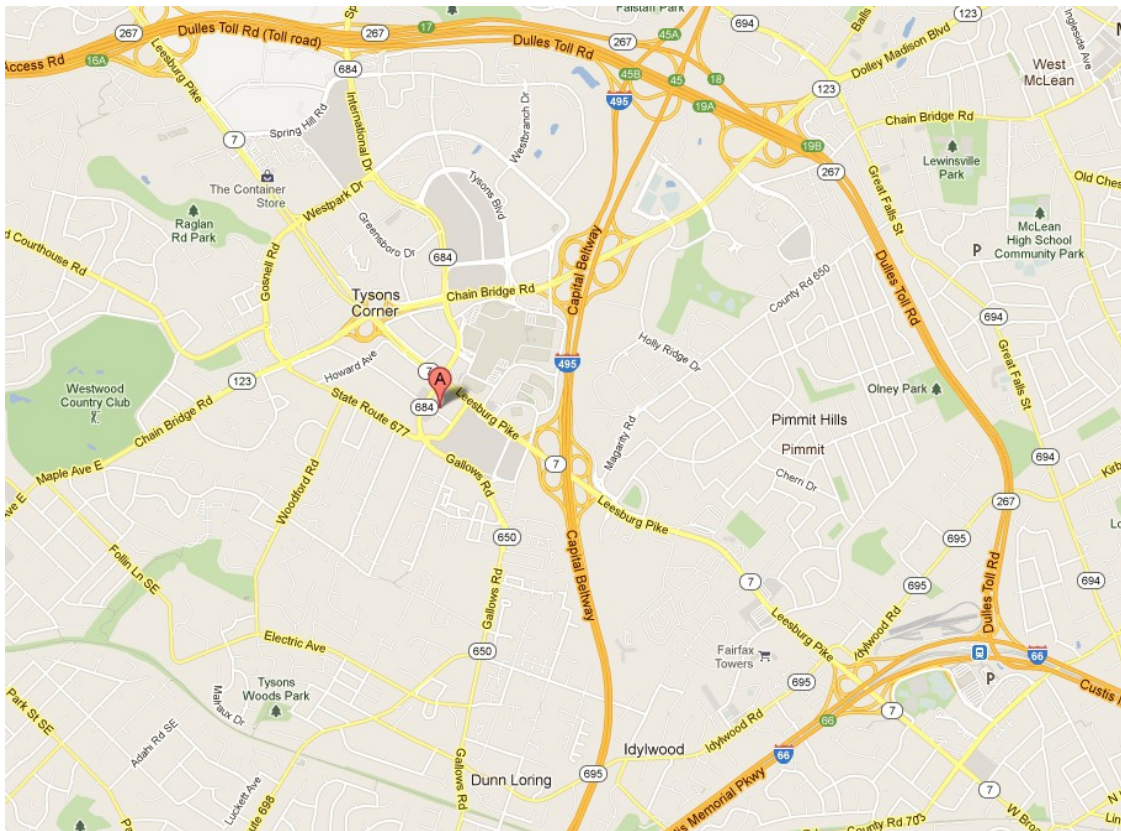
Thank you for entrusting your health to The Grove Center for Chiropractic & Wellness, Inc. We will do our utmost to provide you with the best possible care and service.

The Front Office handles all patient scheduling and any financial/insurance questions you may have.

Office Phone: (703)760-8110 Fax: (703)760-8111

Email: FrontOffice@grovewellness.com

Hours:	Monday	7:30AM	to	4:00PM
	Tuesday	7:30AM	to	7:00PM
	Wednesday	7:30AM	to	7:00PM
	Thursday	8:30AM	to	1:30PM
	Friday	7:30AM	to	4:00PM



**GPS directions may not always be accurate. Feel free to ask Front Desk staff for directions once you are in the Tysons area.

CHIROPRACTIC REGISTRATION AND HISTORY

Kirsten S. Grove, DC, CCSP • 8130 Boone Blvd. Suite 110 • (703) 760-8110

Patient's Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Sex: M _____ F _____ Age: _____ Birth date: _____ SSN: _____

Single: _____ Married: _____ Widowed: _____ Separated: _____

Email: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Occupation: _____

Reminder Call Preference: Home: _____ Cell: _____ Work: _____ Email: _____

Who may we thank for referring you? _____

Name of emergency contact: _____ Relationship: _____

Best phone number to reach emergency contact: _____

Reason for visit: _____

Is the condition getting progressively worse? ___Y ___N ___ Unknown

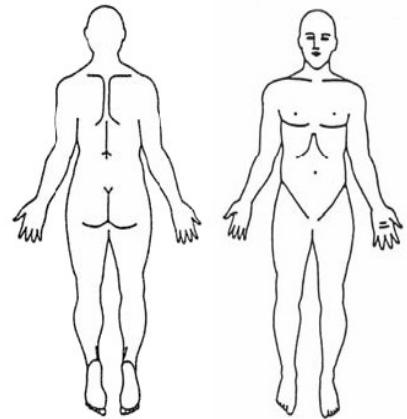
Rate the pain, on a scale from 1 (least) to 10 (most severe): _____

***PLEASE INDICATE AREAS OF PAIN ON THE DIAGRAM**

When did symptoms appear? _____

Is the pain constant or does it come and go? _____

What are your goals for treatment? _____



Type of pain: Sitting _____

Sleep _____

Sharp _____ Burning _____ Standing _____

Recreation _____

Dull _____ Tingling _____ Walking _____

Daily routine _____

Throbbing _____ Cramps _____ Bending _____

Shooting _____ Numbness _____ Lying down _____

Stiffness _____ Aching _____

Swelling _____ Other _____

Does it interfere with:

Painful activities: Work _____

Additional Information

Recreational life: _____

Rest and sleep: _____

Have you ever been in an automobile accident? _____ When? _____

Any accidents, falls, etc., that may have caused your problem? _____

Any medical diagnosis of your condition? _____

Drugs you now take: _____

Allergies to any medications? _____

Date of last Menses: _____ Are you pregnant? _____

Have you consulted a chiropractor in the past? Y ___ N ___ (Name): _____

Date consulted: _____ For what conditions? _____

History of all major past illnesses or surgeries (include date and area of body affected):

Regular exercise programs (type and frequency): _____

Any particular sport you play? _____ Hours per week: _____

Do you smoke?: _____ Amount per week?: _____ Alcohol consumption? _____

Number of drinks: _____ per Day Week Month (circle one) _____

Are you presently using any type of back or arch supports, orthotics, heel lifts, or braces, of any kind?

Yes: ___ No: ___ Describe: _____

Have you ever been treated for:

- | | | |
|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Liver trouble | <input type="checkbox"/> Nervous condition |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Neck problems |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Previous food condition |

FINANCIAL POLICY

Thank you for choosing our practice for your chiropractic care. We are committed to providing the best treatment for our patients, and we appreciate your trust in us. To help us serve you, please provide us with accurate and complete insurance information. Insurance policies are arrangements between the carrier and the patient. The patient is ultimately responsible for the payment for all services received from this office.

Payment is due in full at the time of service (includes insurance deductibles and co-payments). We accept cash, checks or VISA/MASTERCARD, and we offer an extended payment plan with prior approval. We process insurance claims only for Blue Cross/Blue Shield related insurance.

Thank you for reviewing our Financial Policy. Please let us know if you have any questions or concerns.

Signature: _____

Date _____

Blue Cross / Blue Shield PPO & Medicare Patients Only:

Please provide the following information:

Patient name: _____ Person responsible for account: _____

Subscriber's Insurance I D #: _____ Group # _____

Insurance Co.: _____ Ins. Co. Telephone: _____

Ins. Co. Address: _____

Is patient covered by additional insurance? _____ Yes _____ No

ASSIGNMENT OF INSURANCE

I, the undersigned, assign directly to Kirsten Grove, D.C. all relevant insurance benefits, if any. I understand that I am financially responsible for all charges not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature _____

Date _____

**KIRSTEN S. GROVE, D.C. DOING BUSINESS AS THE GROVE CENTER FOR
CHIROPRACTIC & WELLNESS INCORPORATED
NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Kirsten S. Grove, D.C. does business as The Grove Center for Chiropractic & Wellness Inc., and thereby is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment:

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.

(Example)

“On occasion, it may be necessary to seek consultation regarding your condition from other healthcare providers associated with Kirsten S. Grove, D.C. dba The Grove Center for Chiropractic and Wellness Inc.”

“It is our policy to provide a substitute healthcare provider, authorized by Kirsten S. Grove, D.C. dba The Grove Center for Chiropractic and Wellness Inc., to provide assessment and/or treatments to our patients, without advance notice, in the event of your primary healthcare provider’s absence due to vacation, sickness, or other emergency situation.”

Our answering machine is not a closed system. When messages are retrieved, there is a chance your message could be overheard. Every effort is made to take messages off the machine with your privacy considered.

Our filing area is monitored by staff, or is locked, and is separated from the treatment rooms.

Workers Compensation:

We may disclose health information as necessary to comply with state workers’ compensation laws.

Emergencies:

We may disclose information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition, or in the event of emergency or your death.

Public Health:

As required by law, we may disclose health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infectious exposure.

Judicial and Administrative Proceedings:

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement:

We may disclose your health information to law enforcement officials for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons:

We may disclose your health information to coroners or medical examiners.

Research:

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety:

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies:

We may disclose your health information for the military, national security, prisoner and government benefit purposes.

Marketing:

We may contact you for marketing purposes or fundraising purposes, as described below: (example)

“As a courtesy to our patients it is our policy to call you on the evening of the day of your first treatment. The purpose of the call is to see how you are feeling and if you have any questions or concerns.”

“It is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this reporting or message, other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.”

“As a service to our patients it is our policy to occasional send a health newsletter or flyer regarding upcoming health classes offered on our premises. It is not our policy to disclose any personal health information about your condition for the purposes of these marketing mailings.”

“It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, postcard, invitation, or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the date and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purposes of these fund raising events.”

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

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

This notice is effective as of ____/____/____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Kirsten S. Grove, D.C. dba The Grove Center for Chiropractic and Wellness, Inc. with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

Patient's Name (print)

Patient's Signature

Date

Authorized Facility Signature

Date

Patient Attendance Policy

In order to assure that all patients receive the time and attention they deserve, we have the following guidelines:

1. If you are late for a scheduled appointment, there is a possibility that you may not be seen that day. We do not run over the original time allotted to your appointment.
2. If you need to cancel an appointment, it must be done at least 24 hours in advance. If your call is not during our normal business hours, please leave a message on our voice mail. There is a \$30.00 fee for a cancellation without proper notice. This charge will not be covered by insurance and will be billed directly to you.
3. Your appointment time is reserved for you. If you do not give the required notice and you miss your scheduled appointment (no call/no show), we have the right to assess a \$50.00 charge. This charge will not be covered by insurance and will be billed directly to you.

"I have read and understand this policy."

Patient/Guardian Signature: _____

Date: _____