Dr. Mark Saracino
Board Certified
Chiropractic Neurologist

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Welcome. Every attempt will be made to make your visits comfortable and beneficial. This could be your first experience with a Chiropractic Neurologist, so if you have any questions please feel free to ask. Please complete this form; the information is important to aid in your prompt recovery.

Name_____Cell / Home Phone_____
Address_____S.S.#_____
City_____State_____Zip Code_____
Date of birth_____/_____/_____ single{ } married{ } divorced{ } widowed{ }
E-mail address_____ number of children_____
Employer_____Occupation_____
Address_____Work Phone_____
City_____State_____Zip Code_____
Describe your daily living/working activities_____
_____
Briefly describe your present ailment_____
_____
Date you first noticed symptoms_____/_____/_____How did they occur?_____
_____
Have you previously experienced similar symptoms?_____When?____/____/_____
Have you ever received manipulations from a physician?_____When?____/____/_____
For what condition?_____
Are you currently receiving treatment from a physician?_____
Doctor's name?_____Phone_____
Address_____
Describe treatment and reason_____
Are you currently on medication?_____What?_____
List major surgical history_____
_____
Whom shall we thank for your referral?_____
Are you presently involved with a special diet, exercise or therapeutic plan ?_____
Describe_____
_____
Special interests/hobbies/activities_____

Payment for services and products is required at the time performed or given, unless other arrangements have been made. When the doctor accepts assignment for your insurance contract, keep in mind that the contract is between you and your carrier only. Any denial of coverage that results in a reduced or nonpayment and leaves a balance to the doctor then becomes your responsibility to pay the doctor, within 15 days notification of denial by the insurance company or this office, whichever comes first. The balance due is then subject to an interest charge of 1.5% per month (18% per annum) on accounts more than 30 days past due, and will accrue from the date of service, not the billing date. An additional 20% attorney's fee will be included should your account be referred to an attorney for collection.

Signature_____date _____/_____/_____

Acknowledgement of Receipt of Notice of Privacy Practices for Protected Health Information I acknowledge that I received Dr. Saracino's Notice of Privacy for Protected Health Information.

Signature_____date_____/_____/_____