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📍 190 Perrin Drive Rochester, NY 14622
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Tina Shores, D.C. | Colby Shores, D.C., CCSP

Pre-Existing Patient Information

Name: _____ Date: _____

Address: _____
(Street) (City) (State) (Zip)

Patient Contact #: (Home)_(____)_____-_____(Cell)_(____)_____-____ Preferred (H | C)

Email Address: _____

Sex:_(Male | Female | Other:_____) Date Of Birth: _____/_____/_____

Emergency Contact

Name: _____ Relationship: _____

Phone #:_(____)_____-_____-_____-_____ Work #:_(____)_____-_____-_____

Medical History

Primary Care Physician: _____ Phone: _____

Office Name: _____

Are you being seen by other specialists? _____

Medication List: _____

Allergies To Medication: _____

Insurance Update Information 2026

Insurance Company: _____

Policy Holder Name: _____ D.O.B.: _____/_____/_____

Policy Number: _____ Group # (If Applicable): _____

Relationship to Policy Holder: Self | Spouse | Child

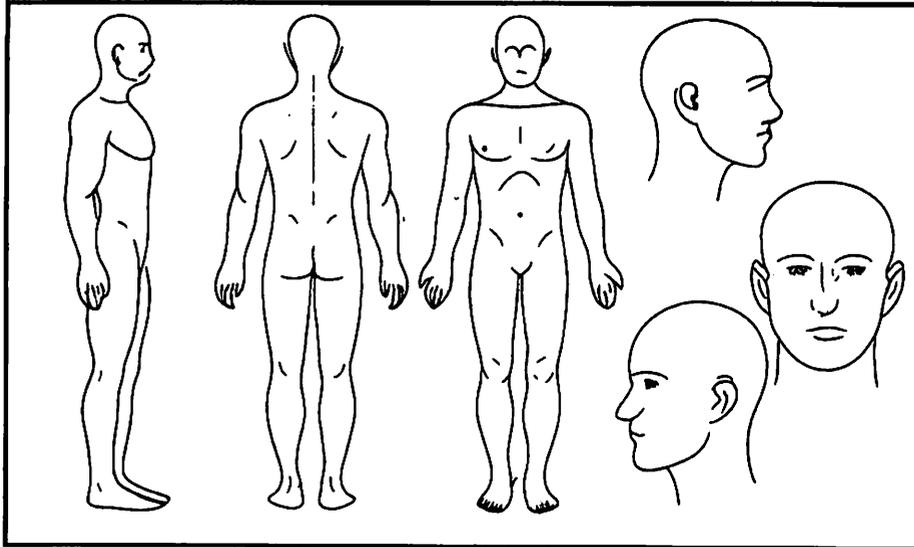


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Patient Name: _____ **Date:** _____

Regular
 Worker's Comp
 No-Fault



On the diagram, please indicate the location of pain and the symbol that best describes what you are currently experiencing:

SHARP/ STABBING ++++
DULL/ ACHY VVVV
PINS / NEEDLES 0000
NUMBNESS /////
OTHER XXXX

Type of discomfort (choose all that apply):

___Sharp ___Dull ___Aching Burning ___Numbness ___Tightness ___Throbbing
 ___Diffuse ___Shooting ___Tingling ___Other: _____

Frequency of Pain:

___Constant ___Frequent ___Intermittent ___Occasional
 (100%-75%) (75%-50%) (50%-25%) (25%-0%)

Discomfort increases with:

___Movement ___Applying Pressure ___Sitting ___Standing ___Coughing
 ___Other: _____

Discomfort decreases with:

___Rest ___Movement ___Medication ___Ice ___Heat ___Chiropractic Care
 ___Other: _____

Region	At WORST	At BEST	TODAY
NECK	012345678910	012345678910	012345678910
MID/UPPER BACK	012345678910	012345678910	012345678910
LOW BACK	012345678910	012345678910	012345678910
Other _____	012345678910	012345678910	012345678910

Office Financial Agreement 2026

Insurance policies are individualized per each patients benefit. Please read and initial next to your benefit plan.

INDIVIDUAL POLICY

____ **Excellus BC/BS, Aetna and United:** Deductibles: Referral may be needed. Until your annual deductible is met, the insurance fee schedule will be procedure-dependent. Once the deductible is met, you will be responsible for the co-insurance policy dependent. Your co-pay is due at the time of service and will range from \$0-\$70, depending upon your contract. Insurance covers acute care and not maintenance care. Supplements are not covered and are the patient's responsibility.

____ **Medicare Advantage Plans: Aetna/BCBS/MVP Gold/United:** Authorization may be required. Some insurances set a number of visits allowed. Some costs are out of pocket per Medicare. Please refer to the ABN agreement. Your insurance covers acute care, not maintenance care.

____ **Medicare:** No referral needed. Until your annual deductible of \$283.00 is met, the insurance fee schedule is \$50-\$100.00. You will be responsible for any usual and customary fee (ABN). Your insurance covers acute care and no maintenance care.

____ **MVP/Cigna/Other:** The doctors in this office are out of network providers. Payment follows the Usual and Customary Fee shown below.

____ **Usual & Customary Fees:** First visit for consultation, history and examination is \$100.00. Subsequent visits thereafter are \$50.00.

____ **Maintenance Care:** Elective healthcare defined as patient has achieved and maintained pre-complaint status, plateaued in improvement, and/or chronic symptoms show no progression in reduction or remain stable. This is a service not covered as per your insurance company policy, and you will be responsible for the office fee of \$50. If you sustain a future incident or injury, your chiropractic care would again meet the criteria for acute care and would be covered by your health plan until that condition has achieved pre-complaint status or plateaued in improvement.

PLEASE READ & INITIAL OUR NEW OFFICE POLICIES

____ **New Patient Appointment Fee: \$50**

All new patients will be charged a \$50 appointment holding fee that will be credited towards your total bill.

____ **Consultation Fee: \$50**

No treatment | 15 Minute Appointment

____ **Missed/ Cancelled Visit w/in 24 Hrs : \$50**

All patients are subject to adhere to a \$50 charge without notice of a missed or cancelled appointment.

____ **No Insurance | Self Pay: \$100 | \$50**

Each visit will be \$50 for all current patients. If you are a New Patient, your initial evaluation will be \$100, then \$50 thereafter per visit.

____ **Our office does not allow a personal balance over \$100. Should your account become 30 days delinquent, a \$10 charge per week will be assessed to the outstanding balance.**

____ **Payment is due at the time of service. Payment in the form of cash, credit or check is accepted. All major credit cards are accepted.**

____ **Returned checks will have a \$25 service charge.**

I understand that I am financially responsible for all charges, whether paid by insurance or self-pay.

Responsible Party Signature

Date

Printed Name