COMPLETE CHIROPRACTIC

AND FAMILY WELLNESS

NEW PATIENT INTAKE

Name: _____ Today's Date: _____

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

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

Email Address: _____ Gender : Male Female Other

Birth Date: _____ Age: _____ Social Security Number: _____-_____-_____

Occupation: _____

Employer Name: _____

Single: _____ Married: _____ Spouse's Name : _____

Emergency Contact: _____

Emergency Relation: _____ Emergency Phone: _____

Have you seen a Chiropractor before? Yes No If so when? _____

Who is Your Primary Care Physician: _____

Whom may we thank for referring you to our office: _____

YOUR HEALTH SUMMARY

Please ☑ check all symptoms you have ever had, even if they do not seem related to your current problem

- ❑ Pins and Needles in arms
- ❑ Dizziness
- ❑ Numbness in fingers
- ❑ Fatigue
- ❑ Sleeping problems
- ❑ Diarrhea
- ❑ Cold sweats
- ❑ Mood swings
- ❑ Headaches
- ❑ Pins and Needles in legs
- ❑ Loss of smell
- ❑ Buzzing in ears
- ❑ Numbness in toes
- ❑ Depression
- ❑ Neck stiff
- ❑ Constipation
- ❑ Neck Pain
- ❑ Menstrual Pain
- ❑ Fainting
- ❑ Back Pain
- ❑ Ringing in ears
- ❑ Loss of taste
- ❑ Irritability
- ❑ Cold hands
- ❑ Fever
- ❑ Problem urinating
- ❑ Menstrual irregularity
- ❑ Loss of balance
- ❑ Nervousness
- ❑ Stomach upset
- ❑ Tension
- ❑ Cold feet
- ❑ Hot flashes
- ❑ Heartburn
- ❑ Ulcer

List any medications and/or supplements that you are taking: _____

_____

_____

Please note any significant personal **or** family medical history: _____

_____

_____

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INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation. You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable. Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being. It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users. It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit. I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I agree that the doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Guardian Name: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

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NOTICE OF PRIVACY & HIPAA ACKNOWLEDGEMENT/CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

This office conforms to the current HIPAA guidelines. You may request a copy of the HIPAA policy at the front desk.

Patient Signature: _____ Date: _____

Guardian Name: _____ Relation: _____

Guardian Signature: _____ Date: _____

PATIENT CONTACT AUTHORIZATION

I give permission to Complete Chiropractic to use my address, phone number, email address and clinical records to contact me with appointment reminders, missed appointment notification, birthday texts, holiday related cards, newsletters, information about treatment alternatives or other health related information.

If Complete Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine/voicemail or with the person who answers the telephone at home, work, or cell number I have provided.

Patient Signature: _____ Date: _____

Guardian Name: _____ Relation: _____

Guardian Signature: _____ Date: _____

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GENERAL INSURANCE FINANCIAL POLICY

IN NETWORK: ***Your insurance is an agreement between you and your insurance company, not between your insurance company and our office.*** We cannot be certain if your insurance covers Chiropractic, although most policies do provide some coverage. The amount they pay varies from one policy to another. We will call to verify your benefits; however, the benefit quote obtained from your insurance company is not a guarantee of payment. The benefits we receive are only as good as the representative giving them. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles, coinsurance or co-pays. Your portion of charges is immediately due upon processing by insurance and will be charged to your card on file.

OUT OF NETWORK: If you have insurance coverage with a company that we are not in network with we will attempt to verify your insurance and share the information with you. We do not accept assignment with all insurance companies. If we do not accept assignment, insurance reimbursement will be sent to you, and your account will be handled in our office as a Cash account. Please see: *"Cash Paying Patients"* on the next page.

SECONDARY INSURANCE: Please inform us of any secondary insurance.

INSURANCE FORMS/PAYMENT: If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office, or a request for more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

INSURANCE POLICY HOLDER INFORMATION

If you plan on utilizing your insurance please fill out the information below with the insurance policy holder's information. If you haven't given your insurance card and a photo ID to the front desk to copy please do so now.

□ **I AM THE POLICYHOLDER** ***(****please* ***only*** *sign and date below)*
□ **I AM NOT THE POLICYHOLDER** *(please fill out information below)*

Policy Holder's Name:_____

Insurance Company:_____ Insurance Member ID:_____

Patient's Relationship to policyholder (circle): **Spouse** **Child** **Other:**_____

Policy Holder's Date of Birth:_____ Insured Member's Phone #: _____

Policy Holder's Home Address:_____

Policy Holder's Place of Employment: _____

Upon signing this notice, I am declaring that I fully understand and consent to the *"General Insurance Financial Policy Section"* of Complete Chiropractic and Family Wellness. **I understand that my insurance is an arrangement between myself and my insurance company, NOT between Complete Chiropractic and Family Wellness and my insurance company.** I also understand that if my insurance does not respond within 60 days, or I suspend or terminate my schedule or care as prescribed by the doctors at Complete Chiropractic and Family Wellness that fees will be due and payable immediately.

Patient's Signature (or guardian of patient is a minor):_____ Date: _____

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NON GENERAL INSURANCE FINANCIAL POLICY

MEDICARE: Our office accepts assignment from Medicare. Reimbursement is sent directly to our office in payment for chiropractic services that Medicare will cover. Medicare will ONLY cover manipulation of the spine. Some of the non-covered services in our office include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

PERSONAL INJURY, AUTOMOBILE ACCIDENTS AND WORKERS COMPENSATION: Separate financial policies are enforced for PI and WC cases. If you were in an automobile accident or seeking workers compensation please let the Complete Chiropractic representative at the front desk no right away. They will direct you with further instructions..

CASH PAYING PATIENTS: If you do not fall under any of the other categories of payment you are a CASH patient. Since there is no insurance to bill and there are no others responsible for your account, you are expected to pay for your visit at the time of service. You may pay with CASH, CHECK, or CREDIT/DEBIT CARD. We do not carry patient balances unless you have signed up for a monthly payment plan. If you would like to see if you can be set up for a payment plan let us know.

OWNERSHIP OF X-RAYS: It is understood and agreed that the payments to the Doctor for X-rays is for the examination of X-rays only. The X-ray will remain in the property of the office. They are kept on file where they may be seen at any time while you are a patient at this office.

ADVANCED BENEFICIARY NOTICE (ABN) WELLNESS/MAINTENANCE CARE

Insurance companies do not pay for everything, even some care that you or your healthcare provider have good reason to think you need. Your insurance will not pay for Chiropractic Maintenance/Wellness Care or services deemed medically unnecessary per insurance.

Verbiage your insurance company may use to describe medically unnecessary treatment may include some of the following:

- Continued chiropractic care for the same or similar condition would not be considered medically necessary.
- Treatment will not be covered when you have recovered from the **ACUTE** stage of an illness or Injury.
- Treatment for a chronic condition if there is no **reasonable** expectation of improvement.
- Treatment to prevent a relapse or exacerbation (maintenance) of a condition.
- Treatment provided on a routine schedule, even if intended to maintain optimal function.
- Services provided after visit allotment per insurance verification/doctor's discretion.

This notice is to inform you of possible non-covered services that you may be responsible for payment. Any services deemed not medically necessary or unpaid by your insurance, will be discounted to our cash fees.

Non-Covered

I understand that I am responsible for all costs associated with chiropractic care, ancillary services, maintenance and wellness visits. My provider has informed me that my insurance company does not pay for certain services including some supportive therapies, and maintenance and wellness visits because my insurance company does not consider them covered services or medically necessary.

Upon signing this notice, I am declaring that I fully understand and consent to the *"Non General Insurance Financial Policy" section and the "ABN Wellness/Maintenance Care" section of Complete Chiropractic and Family Wellness* and agree to pay all uncovered services.

Patient's Signature (or guardian of patient is a minor):_____ Date: _____

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AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Complete Chiropractic and Family Wellness to release my medical and/or billing information to the following individual(s):

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____

Patient Information:

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that the information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the recipient. You have the right to revoke this consent in writing.

Patient Signature: _____ Date: _____

Guardian Name: _____ Relation: _____

Guardian Signature: _____ Date: _____