NEW PATIENT INTAKE FORMS

PATIENT INFORMATION

First Name:	Last Name:	Date: / /
Soc Sec #:	DOB: / /	Sex: ☐Male ☐Female
Marital Status:	# of Children:	Occupation:
Street Address:		Height: ft. in.
City:	State: Zip:	Weight: lbs.
Email:	Cell Phone:	Other Phone:
Emergency Contact:	Emergency Relation:	Emergency Phone:

How did you hear about our office?

Who is your Primary Care Physician?

Date and reason for your last doctor visit:

Are you also receiving care from any other health professional? ☐Yes ☐No
If yes, please name them and their specialty:

Please note any significant family medical history:

HEALTH HISTORY

Please list any drugs/medications/supplements/vitamins/herbs/other that you are taking, and why:

Have you had any hospitalizations, surgeries or other injuries in the past? ☐Yes ☐No
If yes, please explain:

Please note any significant past medical history:

Exercise Frequency? ☐None ☐1-2x per week ☐3-5x per week ☐Daily

What types of exercise?

HEALTH HISTORY continued

Do you smoke? ☐Yes ☐No	If yes, amount per day:	How many years?
Do you drink alcohol? ☐Yes ☐No	If yes, amount per day:	Type?
Diet: ☐Standard American ☐Paleo-Mediterranean ☐Vegetarian ☐Vegan ☐Gluten Free ☐Other		

ACKNOWLEDGEMENT AND INFORMED CONSENT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature: _____ Date: / /

Parent/Guardian Signature: _____ Date: / /

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VISUAL ANALOG SCALE (VAS)

What health condition brings you into our office?
Have you received care for this problem before? ☐Yes ☐No If yes, please explain:
When did the condition first begin?
How did the problem start? ☐Gradually ☐Suddenly ☐Post-Injury ☐Unsure
When do you notice it most? ☐AM ☐PM How long does it last? ☐Minutes ☐Hours ☐Days
What makes it feel better?
What makes it feel worse?
Have you lost time from work because of it? ☐Yes ☐No If yes, how many days?
Are you pregnant? ☐Yes ☐No If yes, how many weeks?

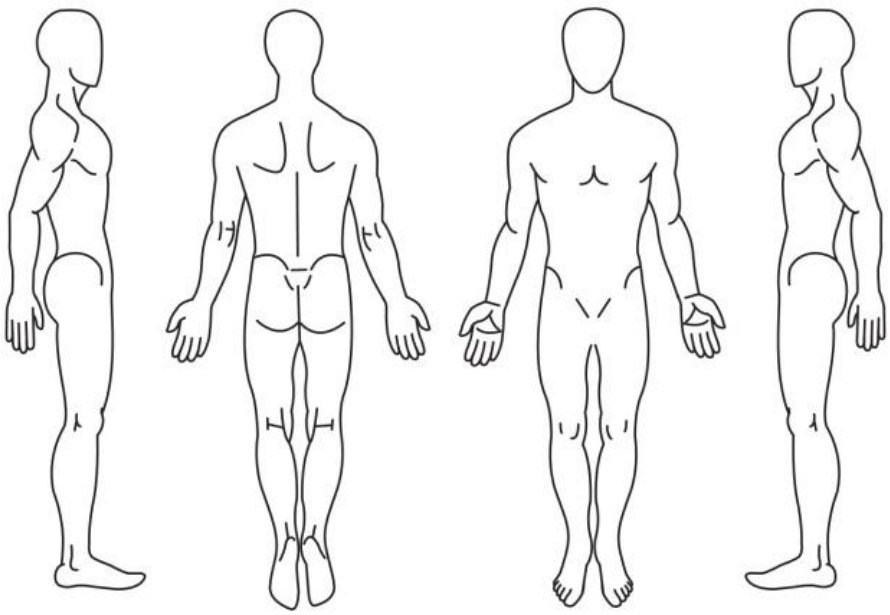
On the scale below, please circle the **severity** of your health condition (at its worst):

NONE		SLIGHT		MILD		MODERATE			SEVERE
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

On the scale below, please circle the **percentage of time** you have experienced your health condition:

OCCASIONAL		INTERMITTENT			FREQUENT				CONSTANT
10	**20**	**30**	**40**	**50**	**60**	**70**	**80**	**90**	**100**

Please indicate below where you are experiencing pain or discomfort by using the following letters:
A: aching **B**: burning **C**: cramping **D**: dull **E**: throbbing **F**: numbness **G**: tingling



Patient Signature: _____ Date: ____/____/____

ACTIVITIES OF DAILY LIVING (ADL)

Please identify how your current condition is affecting your ability to perform activities that are routinely part of your daily life. Please check an answer for each activity listed below:

ACTIVITES	NO PROBLEM	PAINFUL (CAN DO)	PAINFUL (LIMITS)	UNABLE TO PERFORM
Your usual work or school activities	☐	☐	☐	☐
Your usual hobbies, recreational or sport activities	☐	☐	☐	☐
Cleaning or doing chores	☐	☐	☐	☐
Gardening or yardwork	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Going up or down stairs	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Running	☐	☐	☐	☐
Sitting to standing	☐	☐	☐	☐
Rolling over	☐	☐	☐	☐
Being on your phone or computer	☐	☐	☐	☐
Driving	☐	☐	☐	☐
Getting into or out of a vehicle	☐	☐	☐	☐
Bending or twisting	☐	☐	☐	☐
Shoveling snow	☐	☐	☐	☐
Raking leaves	☐	☐	☐	☐
Performing sexual activity	☐	☐	☐	☐
Lifting or carrying	☐	☐	☐	☐
Pushing or pulling	☐	☐	☐	☐
Dressing or grooming	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐
Squatting	☐	☐	☐	☐
Hopping, jumping or skipping	☐	☐	☐	☐
Preparing food or cooking	☐	☐	☐	☐
Reading	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐

OFFICE POLICIES

1. Please be on time for your appointment. Being late or last minute cancellation will cause severe scheduling disruptions, which can interfere with the quality of care you and other patients receive.

2. Continued cancellations or missed appointments may result in being released from care. If you need to reschedule an appointment, please call within 24 hours of your scheduled appointment.

3. Children are welcome here as patients. If you bring children with you for your appointment, you are responsible for their actions at all times.

4. We may schedule you for multiple appointments. This will help ensure convenient appointment times for you, as well as provide you with the highest level of care possible.

5. Please notify our office when you have a change of address, phone number, and insurance information or of any changes in your health status.

FINANCIAL POLICIES

1. Missed appointments are a loss for everyone! Please understand that when an appointment is made, that time is reserved especially for you. If your appointment is broken or cancelled less than 24 hours prior to the appointment time, we find it necessary to charge a fee equal to the fee allotted to that appointment time ($45.00). It is your responsibility to keep or cancel your appointment, whether or not we are able to contact you for confirmation. We will be unable to reschedule appointments if you have three or more broken appointments, without the proper notice.

2. All services are payable in full at time of treatment, unless other arrangements are made in advance. We accept the following forms of payment: cash, personal check, debit and credit cards (American Express, Discover, MasterCard, Visa and your HSA Card). There is a $35.00 charge per occurrence for all returned checks or rejected credit card payments.

3. Insurance coverage is a contract between the patient and the insurance carrier. It is a benefit to the patient and should be considered only an adjunct to chiropractic treatment. We will gladly file your insurance claim for you and accept assignment of benefits. However, insurance companies will never allow that a quote of benefits is a guarantee of payment. We are not responsible for your insurer's final payment and benefit determination. We will determine, to the best of our ability, from your insurance company the amount of coverage for your procedure. You will be responsible for payment of your copay, co-insurance and deductible amount. This may be collected at time of service if known or billed once the insurance company makes their determination. **Your signature below assigns assignment to this office for collection of benefits and also authorizes this office to release daily chart notes when necessary for the processing of claims.**

4. Patients without insurance will be required to pay for your services at the time they are rendered.

5. Medicare/Medicare Advantage Patients: Medicare Part B only covers manipulation of the spine. All other services are not covered and will be your responsibility. You will be required to meet your annual Part B deductible, pay the allowed fee on the spinal manipulation, and 100% of all non-covered services. Medicare Part B patients with a Supplemental Policy will generally have their Part B deductible and the 20% covered by the supplement. However, Supplemental Policies generally do not pay for services that Medicare does not allow. **Medicare patients will be required to sign an Advance Beneficiary Notice (ABN) prior to starting care; any time there is a significant change**

in diagnosis and/or at the beginning of each year. Medicare Advantage plans generally follow the same guidelines as Medicare Part B, except you may have copay instead of a deductible/20% plan.

6. Personal Injury/Workman's Compensation: Most Personal Injury and Workman's Compensation claims are covered 100%. However, it is your responsibility to provide our office with the documentation necessary to prove a valid claim, as well as the name(s) of any claims adjuster/attorney, etc. handling the case, claim numbers and mailing address to send bills. Failure to provide the documentation needed will result in immediate conversion of your case to cash, and all payment will be due on receipt.

7. The Office Manager may approve account balances. Active monthly payments are required. Any account where no payment has been received for ninety days will be sent to a collection agency. Any additional collection fees will be the responsibility of the patient.

It is our sincere intention to provide the best chiropractic care available at the most reasonable fees. Also, we hope that by providing you with the above information, no misunderstandings will arise as we proceed with your treatment. Please feel free to ask questions or make suggestions. We are here to assist you in any way possible.

I have read and understand the financial policy of S.P.A.R.C. Chiropractic. I understand that I am ultimately financially responsible for all services not paid by insurance or other third party. Should there be a balance due at the end of my treatment plan, I will receive an invoice for the amount and pay it promptly, or contact the office to make payment arrangements.

Patient Signature: _____ Date: ____/____/____

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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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We may call you by name in the waiting room when your physician is ready to see you. We may contact you by phone and leave messages or email regarding missed appointments or appointment reminders.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law: Communicable Diseases, Health Oversight, Abuse or Neglect, Food & Drug Administration requirements, Legal proceedings, to Law Enforcement, to Coroners, to Funeral Directors, and Organ Donation, for Research, and Military Activity and National Security purposes, for Worker's Compensation claims, to Personal Representatives, to our Business Associates – billing services, clearinghouses, etc., Family and friends: If you do not express an objection or are unable to object to such a disclosure, we may disclose such information, as necessary, if we determine that it is in your best interest based on our professional judgement.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke an authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your PHI.

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before September 1, 2020.

I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the physician. I further understand that this office reserves the right to amend this notice 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 read.

Patient Signature: _____ Date: ____/____/____

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