Community Chiropractic

DATE: _____

Patient Intake Form

Patient Information

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

Email _____

Date of Birth _____ Gender M ___ F ___ Height _____ Weight _____

Marital Status: Single ___ Married ___ Divorced ___ Widowed ___

Employer _____

Occupation _____

In case of emergency, contact _____

Phone _____

Who may we thank for referring you? _____

Have you ever received Chiropractic care? Yes __ No __ When was your last visit? _____

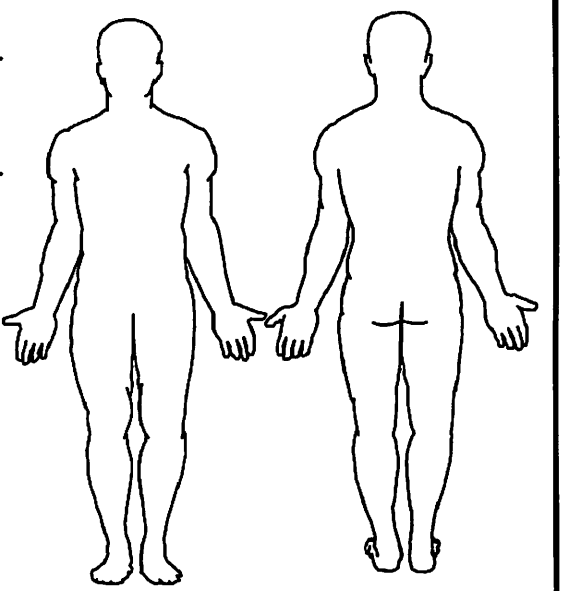
How can we help you?

What brings you in today? _____

Describe your symptoms: _____

What date did your symptoms begin? _____

Please circle areas on the image to the right where you have discomfort:



Have you recently experienced any trauma? YES NO

Is there anything that makes this problem better or worse? _____

Are symptoms occasional, frequent, or constant?

Do you feel symptoms more in:
AM Mid-day PM

How is your sleep?
Good Poor Terrible

Have you experienced any unexplained weight changes in the last 2 months? YES NO

Have you recently had a fever? YES NO

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HEALTH HISTORY

What treatment have you already received for your condition?

_____ Medications _____ Surgery _____ Physical Therapy

_____ Chiropractic Services _____ None _____ Other _____

Name of doctor(s) who treated you _____

Date of last:

Physical Exam _____ X-ray _____

MRI, CT-Scan, Bone Scan _____

OBGYN Exam _____

Any past surgeries? _____

Significant family health issues: _____

Please circle "yes" or "no" to indicate if you have had any of the following:

Bleeding Disorders	YES	NO	OBGYN Issues	YES	NO
Cancer (type)_____	YES	NO	Osteporosis	YES	NO
Diabetes	YES	NO	Pace Maker	YES	NO
Emphysema	YES	NO	Parkinson's Disease	YES	NO
Epilepsy	YES	NO	Polio	YES	NO
Goiter	YES	NO	Prostate Issues	YES	NO
Gout	YES	NO	Rheumatoid Arthiritis	YES	NO
Heart Disease	YES	NO	Sexually Transmitted		
Hepatitis	YES	NO	Disease	YES	NO
Herpes	YES	NO	Stroke	YES	NO
High Blood Pressure	YES	NO	Thyroid Problems	YES	NO
High Cholesterol	YES	NO	Tuberculosis	YES	NO
Kidney Disease	YES	NO	Tumor, Growths	YES	NO
Liver Disease	YES	NO			
Migraines	YES	NO			
Multiple Sclerosis	YES	NO			

Are you currently taking any medications? Medication Name Dosage/Frequency

Medication Allergies: _____

Smoking Status (Circle One): Every Day Smoker/Occasional Smoker/Former Smoker/ N/A

Alcohol Status (Circle One): Every Day Drinker/Occasional Drinker/Former Drinker/ N/A

Consent to Examine and Treat

Dr. Curtis Damien – Dr. Jeff Smith
Community Chiropractic

The undersigned consents to any examination (x-ray or otherwise) including, but not limited to, physical, orthopedic and neurological evaluation, visual inspection, palpation and X-rays if needed.

The undersigned also consents to observation of therapeutic or diagnostic procedures by staff personnel. Treatment procedures that may be used in your treatment include, but are not limited to, manipulative therapy, joint mobilization, myofascial release, trigger-point therapy, ultrasound, electrical muscle stimulation, rehabilitative exercise, infrared therapy, low level laser, traction, decompression. Home care instructions will be given as appropriate to enhance your treatment program. Compliance with the recommendations for home care and follow-up care is necessary for the resolution of your complaint.

Because of modern techniques and equipment, examination and therapeutic procedures carry with them a low risk of complication. Even though problems seldom arise during these procedures, risks must be recognized and considered. While examination and therapeutic procedures used in this clinic are considered remarkably safe and effective, understand that occasionally there may be adverse reactions that occur. Although the chances of experiencing any of these complications are extremely small, it is the practice of this office to fully inform and educate our patients. These complications include but are not limited to pain, swelling, bruising, discoloration, inflammation, disc injury, sensory changes, fracture, fainting, irregular heartbeat, heart attack, spinal cord damage, nausea, burns, soft tissue injury, stroke, dizziness, or weakness. No guarantee or warranty for a specific cure or result is implied by the acceptance of your case. All patients respond differently to the treatment procedures and each case must be evaluated separately.

If you do not fully understand the above or have questions about anything mentioned in this document, please do not sign it until these matters have been resolved with further discussion.

I have read the above explanation of treatment and diagnostic procedures used in this clinic and have decided that it is in my best interest to submit to these procedures.

Signature:_____ Date:_____

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by COMMUNITY CHIROPRACTIC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. If you would like a full copy of the Notice of Privacy Policy, please notify staff.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information. This must be received in writing. Any use or disclosure that has already occurred prior to the date which your revocation of consent is received will not be affected.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Our office staff may use your name in open/common treatment areas in your presence when other patients are present and are able to hear your information.

Patient Authorization

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed (choose one)

The information covered by this authorization includes:

All info ____ Diagnosis/Treatment Plan ____ Appointments ____ Billing _____

Persons Authorized to Use or Disclose Information (family member or medical facility)

Information listed above is authorize to be released to:

_____

Name of Person Organization

Expiration Date of Authorization (specific date or through end of treatment)

This authorization is effective through _____ unless revoked or terminated by the patient or patient's personal representative.

By my signature below I give my permission to use and disclose my health information.

_____ _____

Patient or Legally Authorized Individual Signature Date

NO SHOW, MISSED APPOINTMENT

OFFICE POLICY

When our office books your appointment, we are setting aside a dedicated time slot for you. We only ask that if you must reschedule your appointment, that you please provide us with at least 24 hour notice. This courtesy makes it possible to give your reserved time slot to another patient who would be more than happy to accept. We do understand this may not always be possible and would just ask you to call as soon as possible.

Every patient in our practice receives this unique reservation. When your appointment is made, a time is reserved and we make arrangements to be ready for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

There is a charge of $25 per visit for not showing up for scheduled appointments without any notification.

*Repeated cancellations or missed appointments will result in loss of future appointment privileges.

_____ _____

Patient Signature Date

COMMUNITY CHIROPRACTIC

FINANCIAL POLICY

I understand that all fees are due at the time of service.

If I am unable to pay my bill in full, I understand that is my responsibility to request a hardship payment arrangement. I understand Community Chiropractic is not obligated to provide a payment arrangement.

For insurance patients, it must be clearly understood that health insurance contracts are between you, the patient, and your insurance company. I understand that the Federal Healthcare Information Portability & Accountability Act, HIPPA, has restricted Community Chiropractic's ability to verify some patient information. Although all efforts will be made to electronically and/or verbally verify benefits with my insurance company, I understand that Community Chiropractic is not responsible for any inaccurate information received from my insurance company. I understand it is ultimately my responsibility to know and understand my chiropractic benefits.

I understand that I am financially responsible for all charges that are not paid by my health insurance.

I understand that I have the right to dispute any billing errors. I understand errors can occur and it is my responsibility to bring it to the attention to the Billing Manager's attention if I feel an error has been made.

I understand I will receive a statement from Community Chiropractic reflecting my financial responsibility on a monthly basis. I agree to pay the balance within 10 days from the date of the statement unless financial arrangements in writing have been made. If I fail to do so, I agree to pay a 1.5% monthly finance charge. The finance charges are based on my month ending balance and will accrue at the end of each billing cycle until the balance is paid in full.

We accept cash, check, all major credit cards, and care credit. There is a $20 fee for any returned check.

By signing below, I acknowledge that I have completely read and understand this policy in its entirety and agree to the conditions within.

_____ _____

Patient Signature Date

Staff Initials _____