Intrinsic Balance
Chiropractic & Health Services

Today's Date: _____ **Signature of Patient:** _____

First Name: _____ **Middle Name:** _____

Last Name: _____ **Suffix:** _____ **Nick Name:** _____

Address 1: _____

Address 2: _____

City: _____ **State:** _____ **Zip Code:** _____

Social Security Number: _____

Please also check preferred contact method for phone and email below

☐ **Mobile Phone:** _____ ☐ **Work Phone:** _____

☐ **Home Email:** _____ ☐ **Work Email:** _____

**By providing my email address, I authorize my doctor to contact me via the email address(es) provided.*

Date of Birth: _____ **Age:** ____ **Gender:** ☐ Male ☐ Female ☐ Unspecified

Marital Status: ☐ Single ☐ Married ☐Other

Please briefly explain your current complaint(s): _____

_____

_____

Is your visit today a result of a motor vehicle accident, on the job injury or any other accident or injury? ☐ Yes ☐ No

Have you had an X-ray, CT scan or MRI of your spine in the past 6 months? ☐ Yes ☐ No

Have you ever been to a chiropractor in the past? ☐ Yes ☐ No

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named here; Dr. Morgan Fountain and/or anyone working in this office authorized by the doctor of chiropractic.

If I have questions, I will take the opportunity to discuss with the doctor of chiropractic named above and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. Furthermore, I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels are in my best interests at the time, based upon the facts then known.

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 treatment recommended by the doctor. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment at this facility.

_____ _____

PATIENT'S SIGNATURE

PATIENT'S REPRESENTATIVE SIGNATURE
(If the patient is a minor or is physically or mentally incapacitated)

____ / ____ / _____

DATE

HIPAA PATIENT AUTHORIZATION FORM

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. You have the right to review our Notice before signing this Authorization and you are advised to do so. This authorization for release of information covers the period of healthcare from **_____, 20__ to _____, 20__**.

The patient understands and agrees that:

The Clinic has a Notice of Privacy Practices. The patient has received, and had the opportunity to review this Notice before signing this Authorization. The Clinic encourages all patients to review the Notice of Privacy Practices.

The Clinic reserves the right to modify the Notice of Privacy Practices to keep up with changes in the law or office practices. We will make all modifications available for review by patients.

All my medical records and protected health information may be disclosed or used for treatment, payment, or health care operations, and for certain marketing purposes. The Clinic will not receive any payment from a third party for marketing purposes in connection with the use or disclosure of your PHI.

The Clinic or its business affiliates may use your PHI to contact you with appointment reminders and educational and promotional items in the future via email, U.S. mail, telephone, fax, and/or prerecorded messages. We WILL NOT ever sell or "SPAM" your personal contact information.

The patient has the right to restrict the uses of his or her information, but the Clinic does not have to agree to all such restrictions.

The patient may revoke this Authorization in writing at any time and all future disclosures that require the patient's prior written authorization will then cease. See the Notice of Privacy Practices for additional details.

The Clinic may not condition your treatment or payment on whether you sign this Authorization.

Information used or disclosed pursuant to this Authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

The Authorization was signed by:

_____

Printed Name - Patient or Representative

_____

Signature **Date**

_____

Relationship to Patient (if other than patient)

Witness:

_____

Printed Name - Clinic Representative

_____

Signature **Date**

For Internal Use:

☐ Patient refused to sign ☐ Patient unable to sign for the following reason: _____

FINANCIAL AGREEMENT

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is **not a substitute for payment**. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance.

In order to control your outstanding balance, it is our policy to collect co-pays, co-insurance and deductible at time of service.

If this account is assigned to an attorney/outside agency for collection and/or suit, Intrinsic Balance shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

_____ _____

PATIENT'S / GUARDIAN'S SIGNATURE **INSURED'S SIGNATURE**

____ / ____ / _____

DATE

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Intrinsic Balance all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim chose in action or right against my insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ ____ / ____ / _____

PATIENT'S / GUARDIAN'S SIGNATURE **DATE**

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Name: _____ **Date:** _____

Personal Health History

Please circle the answer that best describes your usual behavior or habits for the following categories:

Work:	*Full-time*	*Part-time*	*Unemployed*	*Retired*	*Student*
Exercise:	*Nearly never*	*Occasionally*	*1-2 days/wk*	*3-4 days/wk*	*5-7 days/wk*
Special Diet:	*Vegetarian*	*Vegan*	*Keto*	*Gluten-free*	*Other*
Caffeine:	*Never*	*Occasionally*	*1-2 cups/day*	*3-4 cups/day*	*5+ cups/day*
Alcohol:	*Never*	*Occasionally*	*1-2 days/wk*	*3-4 days/wk*	*5-7 days/wk*
Smoking:	*Never*	*Used to*	*<1 pack/wk*	*1-2 packs/wk*	*3+ packs/wk*
Drugs:	*Never*	*Used to*	*Current user*		

Please list any allergies you have:

_____

Please list any medications you are currently taking:

_____

Please list any accidents/traumas, past or current, that may pertain to your complaints:

_____

Please list any surgeries that you have had:

_____

Please circle any health problems you experience or have been diagnosed with:

Poor Posture	*Osteoporosis*	*Arthritis*	*Gout*	*Scoliosis*
Seizures	*Pins and Needles*	*Numbness*	*Dizziness*	*Memory Issues*
Depression	*Anxiety*	*Stroke*	*TMJ*	*Ear Infections*
Headaches	*Migraines*	*High Blood Pressure*	*Low Blood Pressure*	*Swelling*
Heart Attack	*Heart Murmur*	*Chest Tightness*	*Shortness of Breath*	*Apnea*
Tuberculosis	*Asthma*	*Reflux*	*Constipation*	*Nausea*
Ulcers	*Kidney Stones*	*Urinary Tract Infection*	*Incontinence*	*Frequent Urination*
Diarrhea	*Thyroid Issues*	*Diabetes*	*Hormone Therapy*	*Steroid Therapy*
Skin Cancer	*Hair Loss*	*Hair/Nail Changes*	*Eczema*	*Acne/Rashes*

Immediate Family History

Please list any major illnesses that members of your immediate family have been diagnosed with (i.e. Cancer, Diabetes, Heart Disease, Arthritic Conditions, Stroke, etc.):

Family Member	Major Illnesses/Conditions