GARNER CHIROPRACTIC & WELLNESS CENTER

NEW PATIENT INTAKE FORM

PATIENT INFORMATION

Name _____ Parent/Guardian Name _____

Address _____ City _____ State _____ Zip _____

Home # _____ Cell # _____ Cell Carrier Name _____

Email _____ Age _____ Patient DOB _____

Sex _____Race/Ethnicity _____ Marital Status _____Number of Children _____

Occupation _____

Current Family Physician _____ Phone # _____

How did you hear about us? _____

INSURANCE

Carrier Name _____ Primary Insured's Name _____

Insured's DOB _____ Social Security # _____

CURRENT HEALTH CONDITIONS

Please list the health concern(s) that prompted this visit (most bothersome to least):

1. _____When/How did it begin? _____

2. _____When/How did it begin? _____

3. _____When/How did it begin? _____

Please rate your pain for the above complaints on a scale of **1** to **10** (0 = No pain, 10 = Worst pain):

Primary Complaint: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second Complaint: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third Complaint: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When is your complaint at its worst? □ AM □ Mid-day □ PM
How long does it last? □ Constant □ On and off throughout the **day** □ On and off throughout the **week**
Is the condition: □ Getting worse □ Improving □ Staying the same □ Unsure
Does this interfere with: □ School □ Sleep □ Daily Routine □ Work □ Exercise □ Other _____

What makes your symptoms better? _____

What makes your problems worse? _____

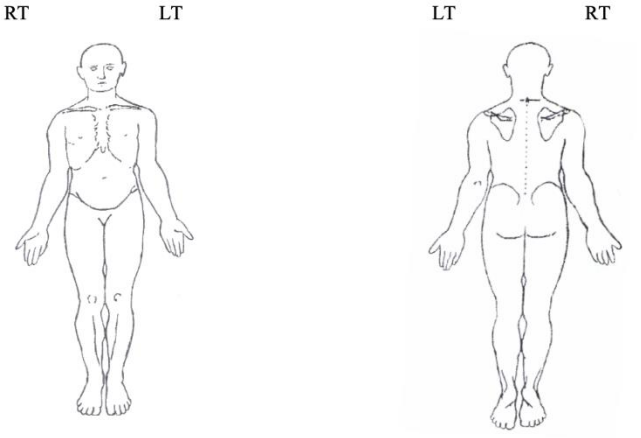
Have you received care for this complaint before? □ Yes □ No If yes, please explain: _____

_____

Have you ever been under chiropractic care in the past? □ Yes □ No Date of last adjustment? _____

Please **mark** the areas on the diagram with the following letters to describe your symptoms:

R = **R**adiating **B** = **B**urning **D** = **D**ull **A** = **A**ching **N** = **N**umbness **S** = **S**harp/**S**tabbing **T** = **T**ingling



Please list any **medications (including over the counter), vitamins, or diet supplements** you **currently** take and why:

_____ for _____

_____ for _____

_____ for _____

Please list any **food intolerance or allergies**:

_____

Please list any **surgeries** you've had and **when** they occurred:

_____

_____

_____

Please list any **significant injuries** (slips, falls, sports related, etc…) and **when** they occurred:

_____

_____

_____

REVIEW OF SYSTEMS:

Cardiovascular	**Present**	**Past**	**Respiratory**	**Present**	**Past**	**Allergic/Immunologic**	**Present**	**Past**
Poor Circulation			Asthma			Hives		
Hypertension			Tuberculosis			Immune Disorder		
Aortic Aneurism			Short Breath			HIV/AIDS		
Heart Disease			Emphysema			Allergy Shots		
Heart Attack			Cold/Flu			Cortisone Use		
Chest Pain			Cough					
High Cholesterol			Wheezing			**Ear, Nose, and Throat**	**Present**	**Past**
Pace Maker						Difficulty Swallowing		
Jaw Pain			**Eyes**			Dizziness		
Irregular Heartbeat			Glaucoma			Hearing Loss		
Swelling of legs			Double Vision			Sore Throat		
			Blurred Vision			Nosebleeds		
Genitourinary	**Present**	**Past**				Bleeding Gums		
Kidney Disease			**Psychiatric**	**Present**	**Past**	Sinus Infections		
Burning Urination			Depression					
Frequent Urination			Anxiety			Gastrointestinal		
Blood in Urine			Stress					
Kidney Stones						**Gall Bladder Problems**	**Present**	**Past**
Lower Side Pain			**Endocrine**	**Present**	**Past**	Bowel Problems		
			Thyroid			Constipation		
Neurologic	**Present**	**Past**	Diabetes			Liver Problems		
Stroke			Hair Loss			Ulcers		
Seizures			Menopausal			Diarrhea		
Head Injury			PMS			Nausea/Vomiting		
Brain Aneurysm						Bloody Stools		
Numbness			**Hematologic**	**Present**	**Past**	Poor Appetite		
Severe Headaches			Hepatitis					
Parkinson's			Blood Clots			**Musculoskeletal**	**Present**	**Past**
Carpal Tunnel			Cancer			Gout		
Vertigo			Bruising			Arthritis		
			Bleeding			Joint Stiffness		
Constitutional	**Present**	**Past**	Fever, Chills			Muscle Weakness		
Weight Loss/Gain			Sweating			Osteoporosis		
Low Energy level			Varicose Veins			Broken Bones		
Difficulty Sleeping						Joints Replaced		
						Neck Pain		
						Low Back Pain		
						Upper Back Pain		

FAMILY HISTORY:

Do any of your family members have any of the following? If yes, state who (father, mother, sister, etc…).

Diabetes □ Parent □ Sibling
Hypertension □ Parent □ Sibling
Heart Disease □ Parent □ Sibling
Cancer □ Parent □ Sibling
Stroke □ Parent □ Sibling
☐ Other _____

SOCIAL HISTORY:

Do you **currently smoke**? □ < 1pack/day □ > 1 pack/day □ Former Smoker □ Never a smoker

Describe your **diet**:

□ Mostly whole, organic foods □ Pretty average □ Vegetarian □ High protein □ High amounts of sugar

□ Fast food □ Special diet _____ □ Other _____

Do you drink **caffeine**: □ Often □ Occasional □ Never

Do you drink **alcohol**: □ Often □ Occasional □ Never

How many glasses of **water** do you drink per day? _____

How many **hours of sleep** do you get per night? _____

Is your **weight** a concern? □ Yes □ No

How would you describe your **overall stress level**? □ Low □ Medium □ High

Do you **exercise**? □ Yes □ No If yes, how many **hours** and what **activity**? _____

HEALTH GOALS

What are your top three health goals?

1._____

2._____

3._____

What would you like to gain from chiropractic care? ☐ Manage existing condition ☐ Overall wellness ☐ Both

I give the doctors at Garner Chiropractic and Wellness Center permission to treat me:

_____ _____

Signature (Parent or Guardian if patient is a minor) **Date**

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Informed Consent Document

PATIENT NAME:_____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:
The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints with a goal of gaining better range of motion, better symmetry and balance, reducing pain, and enhancing how you feel. That may cause an audible "pop" or "click", much as you experience when you "pop" your knuckles. You may feel a sense of movement.

Examination / Analysis / Treatment:
As part of the examination, analysis, and treatment, Garner Chiropractic is fortunate to have some of the most up-to-date and advanced technologies listed below. Any may benefit your treatment/condition. You are consenting to the following procedures:

____ I consent to **any/all treatments/protocols** the doctor believes will help me/my condition.

____ I consent **ONLY** to the following, which I have initialed:

_____ spinal manipulative therapy
_____ range of motion testing
_____ muscle strength testing
_____ ultrasound
_____ radiographic studies
_____ palpation
_____ orthopedic testing
_____ postural analysis

_____ hot/cold therapy
_____ acupuncture
_____ power-vibe rehab
_____ vital signs
_____ basic neurological testing
_____ electrical muscle stimulation (EMS)
_____ rehab/exercises
_____ nutritional recommendations

_____ other (please explain) _____

The material risks inherent in chiropractic adjustment:
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include, but are not limited to: fractures, disc injuries, dislocation, muscle strain, cervical myelopathy, costovertebral strains and separations, and skin irritations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to, or contributing to, serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contra-indications to care. However, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform the doctor(s).

The probability of those risks occurring:
Fractures are rare occurrences and generally result from some underlying weakness of the bone which is checked for during the compilation of your history and during examination and X-Ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are described generally as rare.

The availability and nature of other treatment options:
Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest,
- Medical care and prescription drugs such as anti-inflammatories, muscle relaxants, and pain-killers,
- Hospitalization, and/or
- Surgery and injections.

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks (death, infections, etc.) and benefits associated with these options, and you may wish to discuss these with your primary care medical physician.

The risks and dangers with remaining untreated:
Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BOX AND SIGN BELOW.

I have read [ ]: or

I have had read to me [ ]:

the above explanation of the chiropractic adjustment and related treatment(s). I have discussed it with Dr. Perry Kirch and/or Dr. Katherine Lucht and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

Date: _____ **Date:** _____

_____ _____
Patient's Name **Doctor's Name**

_____ _____
Signature **Signature**

_____
Signature of Parent or Guardian (if a minor)

1428-D Aversboro Rd
Garner, NC 27529
Perry J. Kirch, D.C.
Katherine Lucht, D.C.

AUTHORIZATION TO TREAT MINOR CHILD

Child's Name _____ Child's Date of Birth _____

Home Address_____

(Street) (City, State, Zip)

Parent's/Guardian's Name _____

Telephone Number Home _____ Work _____ Cell _____

I, the parent or guardian named above, authorize the above physicians and staff to treat the above named minor child.

SIGNATURE

Parent or Guardian _____ /_____

Printed Name Signature

Date _____

NOTICE OF PRIVACY PRACTICES

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**.

YOUR RIGHTS

Get an electronic or paper copy of your medical record

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request but we will tell you why in writing within 60 days.

Request confidential communications

You can ask us to contact you in a specific way (for example: home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request and we may say "no" if it would affect your care.

ONLY if you pay for a service or health care item out-of-pocket, in full, at the time of service, can we comply with your request (i.e. your request is to not file your claims to your insurance company) not to share that information for the purpose of payment or our operations with your health insurer. Otherwise, we will say "yes" unless a law requires us to share that information.

Get a list of those with whom we have shared information

You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosures except for those about treatment, payment, and health care operations and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights have been violated

You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations below, talk to us. Tell us what you want us to do and we will follow your instructions.

In these situations, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation.
- Contact you for fundraising efforts*.

If you are not able to tell us your preference (i.e. if you are unconscious) we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

***We may contact you for fundraising efforts but you can tell us not to contact you again.*

In these situations, we never share your information unless you give us written permission:

- Marketing purposes.
- Sale of your information.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways:

- **Treat You**
  We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
- **Run our organization**
  We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*
- **Bill for your services**
  We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance so it will pay for your services.*

How else can we share or use your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.
For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- **Help with public health and safety issues**
  We can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health or safety.
- **Do research**
  We can use or share your information for health research.
- **Comply with the law**
  We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- **Respond to organ and tissue donation requests**
  We can share health information about you with organ procurement organizations.
- **Work with a medical examiner or funeral director**
  We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- **Address workers' compensation, law enforcement, and other government requests**
  We can use or share health information about you: for workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services.
- **Respond to lawsuits and legal actions**
  We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective January 16, 2019

Name: _____

Signature: _____ Date: _____
Parent signature if patient is under 18 years of age

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CHIROPRACTIC & WELLNESS
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OFFICE POLICY

1. We will try to assist the patient whenever possible, but it must be understood that: waiting for insurance payments is a courtesy that may be withdrawn at any time. We will bill your **primary** insurance carrier only. You will be responsible for billing your secondary insurance carrier.
2. We file claims in a timely manner and expect insurance payments to be timely as well. Payment should be made in 30-90 days. If the insurance carrier fails to pay in that time, the patient must pay all fees in full.
3. Patients are required to pay their deductible, co-insurance, and/or co-pay required by their insurance plan. We will file insurance toward your deductible.
4. If the patient discontinues care, or is discharged by the doctor, the bill is due in full immediately.
5. If the patient fails to keep scheduled appointments, they can be discharged from care. The bill is then due in full immediately.
6. When we receive an insurance payment, and if a balance is due, you will be notified.
7. As a service, we will get an estimated verification of benefits for you. This is not a guarantee that your insurance company will pay.
8. We will not enter a dispute with your insurance company over payment or coverage. This is your responsibility.
9. Any costs incurred Garner Chiropractic & Wellness Center to collect any unpaid balance will be your responsibility.
10. There may be an additional charge for any extra paperwork required for settling accounts by you or your insurance company(ies).
11. A two percent (2%) interest charge per month will be assessed on any balance 30 days past due.
12. You are required to keep us current with information regarding insurance coverage.

If you have any questions on any of the statements provided above, please ask before signing below. We are happy to answer any questions. The above statements are provided to inform all parties of their responsibility so that there are not any surprises or questions regarding payments.

I hereby state that I have read and understand the terms of the Garner Chiropractic & Wellness Center, PLLC. office policy and that I agree with and will abide by the terms set forth.

Patient Signature: _____ Date: _____

Parent signature if patient is under 18 years of age.