My Chiropractic Doctor

Patient Intake Form

Patient Information

Full Name _____ **Date:** _____
First MI Last

Address _____ **City** _____ **State** _____ **Zip** _____

Age _____ **Birthdate:** _____ Male: ____ Female: _____ **Marital Status:** _____

Social Security Number: _____ **Email** _____

Home Phone: _____ **Work Phone:** _____ **Cell/Other:** _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA **Text Message** to my cell phone: **Y / N** **Please list your cell phone carrier:** _____

Employer: _____ **Occupation:** _____

How did you hear about our office? _____

Primary Language Spoken_____ Race_____ Ethnicity_____

Emergency Contact Information

Spouse's Name: _____ **Spouse's Date of Birth:** _____

Emergency Contact: **Emergency Contact Phone Number:** _____

Payment Information

Please have your insurance card and photo ID ready so they can be copied for the clinic's records.

Person Responsible for Payment: _____ Phone**:** _____

Do you have health insurance**?** ☐ Yes ☐ No Who is the policy holder? _____

Policy Holder's date of birth: _____

Financial Responsibility: I understand that insurance billing is a courtesy provided to me by My Chiropractic Doctor and I am at all times financially responsible for any charges no covered by health care benefits. I understand copays, co-insurance, and deductibles are due at the time of my visits as well as any prior balance I may owe. I understand that I assign benefit to be paid by my insurance company directly to the provider of services rendered to me. I understand my balance will automatically be referred to an outside collection agency should my account surpass 90 days without payment activity. I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for medical services and / or supplies received.

Authorization for Release of Information

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 allow us to give information to family members indicated below.

I authorize My Chiropractic Doctor to release my medical and / or billing information to the following individual (s):

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

Consent for Treatment

Assignment & Release- By signing below, I authorize My Chiropractic Doctor to release medical records required by my insurance company(s).
I authorize my insurance company(s) to pay benefits directly to My Chiropractic Doctor and I agree that a reproduced copy of this authorization will be
as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment and health care operations**.**

By signing below, I give my consent for examination and the performances any testes or procedures needed. I, the undersigned, understand and agree

If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.

Patient/Guardian Signature _____ Date _____

Office Policies

Re-exam Policy: If a patient has not been seen in our office for 90 days, they present with a new injury or area of complaint, or if insurance has changed they will be subject to a re-examination and a subsequent re-exam charge.
Cell Phone Policy: In an effort to keep a relaxing environment, please silence your cell phones and all electronic devices while in the office and please step outside to make or receive phone calls.
NO SHOW POLICY
Due to high demand of appointments and in order to be respectful of the chiropractic needs of all our patients please be courteous and call our office promptly if you are unable to attend an appointment. We always have patients on a cancellation list that need care.

If you are unable to keep your scheduled appointment, we require 24-hour notice.

There will be a $25 charge for every appointment missed without proper notification.

I, the undersigned, understand and agree to the above and, in order to be accepted as a new patient in this office, agree to abide by these policies.
Signature_____ Date _____

My Chiropractic Doctor
Health Questionnaire

Patient Information

Patient Name _____ **Date of Birth** _____

Medical History

Describe your reason for today's visit: **Date of Onset:** _____

Describe onset: Acute Chronic Gradual **Cause:** Unknown Accident

Prior pain to this area: None On and off for years Years ago **Side**: Left Right Bilateral

Describe your pain: (Circle one or more) Achy Burning Dull Sharp Stiff Throbbing

Description of Pain: Mild Moderate Severe **Pain level (1-10):** _____

Does the pain radiate to other areas? _____

When is your pain the worst? Morning As day progresses Afternoon Evening During the night No change

What exacerbates this condition? _____**What alleviates symptoms?** _____

Do you have numbness? Y / N If so, where? _____

Do you have spasms? Y / N If so, where? _____

Do you have weakness? Y / N If so, where? _____

Do you have limited range of motion? Y / N If so, where? _____

Pain with movement? Y / N If so, where? _____

History of Treatment

Primary Care Physician _____**Phone** _____

Have you seen another doctor for these symptoms? If yes, who? _____

List all prescription, nonprescription medications and other supplements you take as well as the associated condition

_____

List any surgeries or hospitalizations you have had complete with the month and year for each _____

_____

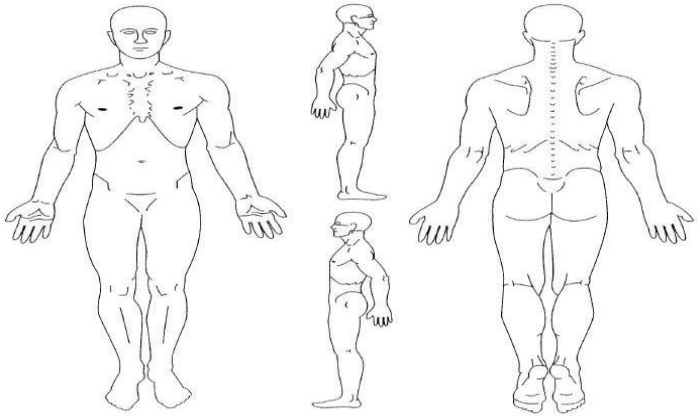
List any allergies _____

Family History (list all major diseases such as cancer, diabetes, heart problems, etc. and the relation to you and the individual)

Do you smoke? □ Yes □ No **If yes, how many packs per day?** _____ **Are you pregnant?** □ Yes □ No

Description of Condition

Please circle the area (s) of discomfort:



Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Review of Systems

(Indicate if you have had conditions in the past or presently have the conditions)

Cardiovascular	Past	Present		**Respiratory**	Past	Present		**Allergic/Immunologic**	Past	Present
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						
Pace Maker								**Ear, Nose and Throat**	Past	Present
Jaw Pain /TMJ				**Eyes**	Past	Present		Difficulty Swallowing		
Irregular Heartbeat				Glaucoma				Dizziness		
Swelling of legs				Double Vision				Hearing Loss		
				Blurred Vision				Sore Throat		
Genitourinary	Past	Present						Nosebleeds		
Kidney Disease				**Psychiatric**	Past	Present		Bleeding Gums		
Burning Urination				Depression				Sinus Infections		
Frequent Urination				Anxiety						
Blood in Urine				Stress				**Gastrointestinal**	Past	Present
Kidney Stones								Gall Bladder Problems		
Lower Side Pain				**Endocrine**	Past	Present		Bowel Problems		
				Thyroid				Constipation		
Neurologic	Past	Present		Diabetes				Liver Problems		
Stroke				Hair Loss				Ulcers		
Seizures				Menopausal				Diarrhea		
Head Injury				Menstrual				Nausea/Vomiting		
Brain Aneurysm								Bloody Stools		
Numbness				**Hematologic**	Past	Present		Poor Appetite		
Severe Headaches				Hepatitis						
Pinched Nerves				Blood Clots				**Musculoskeletal**	Past	Present
Parkinson's				Cancer				Gout		
Carpal Tunnel				Bruising				Arthritis		
Vertigo				Bleeding				Joint Stiffness		
				Fever, Chills				Muscle Weakness		
Constitutional	Past	Present		Sweating				Osteoporosis		
Difficulty Sleeping								Broken Bones		
Weight Loss/Gain								Joints Replaced		

Patients Signature: _____ Date: _____

My Chiropractic Doctor

Late and Missed Appointment Policy

At My Chiropractic Doctor Clinic, we trust you to keep your appointment. When we schedule an appointment, a specific amount of time is reserved especially for you. If for any reason you do not cancel or change your appointment, it is important that you notify our office at least 24 hours in advance to offer it to someone else.

- First Missed Appointment - If an appointment is missed or canceled within the 24 hour period, we may waive the missed queue appointment fee.
- Second Missed Appointment: After your second missed appointment, we reserve the right to charge up to $ 25 for each scheduled half-hour appointment.

We understand that true emergencies happen. If this is the case, please send us a doctor's note or other appropriate proof and the missed appointment will be removed from your account record.

Late arrival

When we set aside time for you, we need all of that time to provide you with the best quality work possible. When it is late, it diminishes our ability to achieve it. If you are more than 15 minutes late, your appointment may be rescheduled to accommodate the needs of those arriving on time for your pre-booked visit. If this happens, it will be considered a missed appointment and you may be charged a fee at the time of the visit.

I have read the above policy. I understand and agree to abide by the terms listed.

Printed Name: _____ Date: _____

Signature: _____

My Chiropractic Doctor

HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights are given to me under the Health Information Portability and Accountability Act of 1996 (HIPAA). Signing this consent allows My Chiropractic Doctor to use and disclose my protected health information for:

- Treatment
- Consulting with other health care providers about my case
- The day-to-day healthcare operations of your practice

I have also received a copy of your *Notice of Privacy Practices*, which more fully explains how my PHI may be used and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice and that I may contact you at any time to get the most current copy.

I understand that I have the right to request restrictions on how my PHI is used and disclosed but that you are not required to agree to these requests. However, if you do agree you must abide by these restrictions.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to that date is not affected.

I HAVE READ THIS CONSENT FORM AND UNDERSTAND WHAT I HAVE READ. I CONFIRM THAT ALL MY QUESTIONS HAVE BEEN ANSWERED AND I AGREE TO THE ABOVE STATEMENTS.

Printed Name: _____ Date: _____
Signature: _____

My Chiropractic Doctor

OFFICE POLICIES

Thank you for selecting our office to provide chiropractic care to you and your family members. Please note the following office policies.

- Payment is required at the time of service or at the time of purchase of any supports or supplies. Payments can be made by cash, Visa, MasterCard, Amex and Discover.

- After your initial visit you will be given a treatment plan. We request that you follow that plan to get the results we both desire. If you need to change an appointment, please keep as close to the original plan as possible so the continuity of your treatment will not be interrupted.

- We require 24 hours' notice if you cannot keep an appointment. All missed appointments will be charged at the regular fee of $25.

- If you are 15 or more minutes late for your appointment, it may need to be rescheduled. One late patient will cause others to be delayed as well. Please contact the office as soon as possible if you know you will be running late.

I have read and understand the policies stated above:

Printed Name: _____ Date: _____

Signature: _____