

Patient Intake Form Patient Information

Full Name: _____ Date: _____
First MI Last

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Birth Date: _____ Female: _____ Male: _____

Email Address: _____

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

I prefer to receive calls at (circle) Home/Work/Cell I am (circle) Under Age18/Single/Married/Divorced/Widowed/Separated

Employer: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

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

Emergency Contact: _____ Emergency Contact Phone Number: _____

Payment Information

Person Responsible for Payment: _____

Phone: _____ Date of Birth: _____

Insurance Information

Do you have health insurance? ____ Yes ____ No

Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's Birth Date:	Policy Holder's Birth Date:
Group Number:	Group Number:
Policy ID Number:	Policy ID Number:
Please have your insurance card and driver's license ready so they can be copied for the clinic's records.	

Consent for Treatment

Assignment & Release - By signing below, I authorize Dr. Sharon Bruce to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Dr. Sharon Bruce 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 any 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 performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient

Signed _____ Date _____

Medical History

Describe the reason(s) for your doctor visit today:

Are you here because of an accident? _____ What type? _____

When did your symptoms start? _____ How did your symptoms begin? _____

What makes your symptoms worse? _____

What makes your symptoms better? _____

How often do you experience symptoms? (Circle one) Constantly Frequently Occasionally Intermittently

Describe your symptoms? (circle all that apply) Sharp Dull ache Numbing Burning Tingling Shooting

Are your symptoms? (Circle one) Getting better Staying the same Getting worse

How do your symptoms interfere with your work or normal activities? _____

Have you experienced these symptoms in the past? _____

History of Treatment

Primary care physician: _____ Phone: _____

Date last seen: _____ May we update them on your condition? ___Yes ___ No

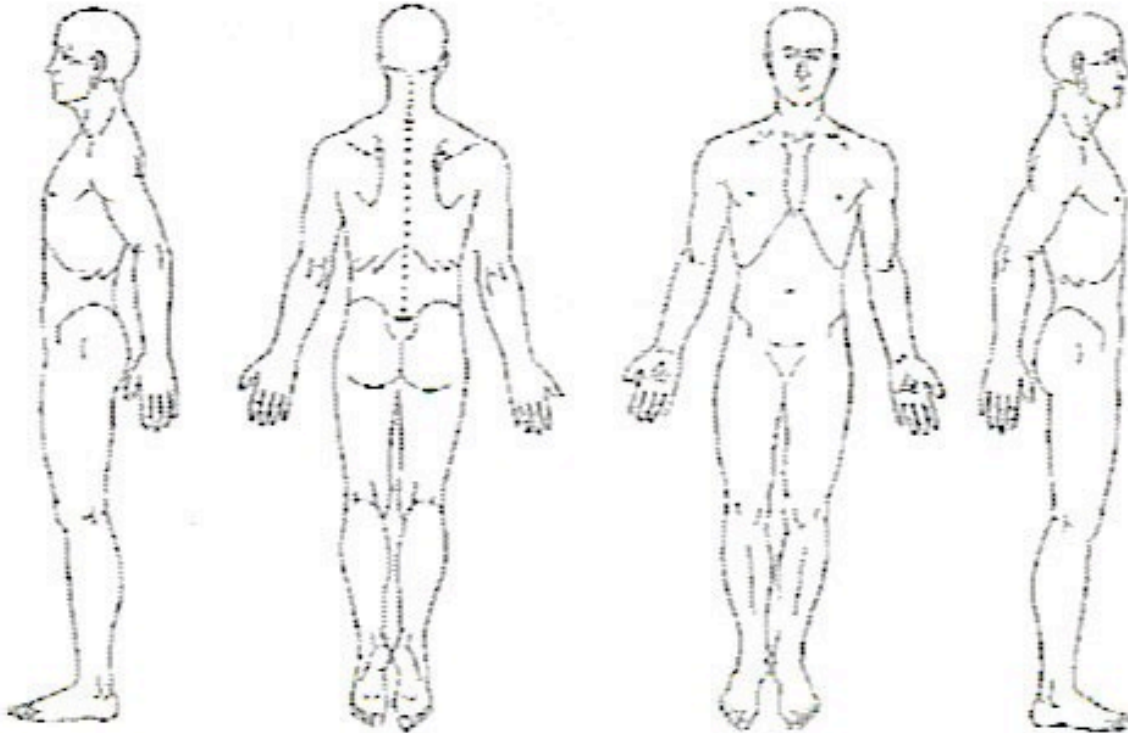
Have you seen a chiropractor before? ___Yes ___ No **Who referred you to us?** _____

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider: _____

Description of Condition

Mark any area(s) of discomfort with the following key:

A =Ache N =Numbness B = Burning T = Tingling S = Stiffness O = Other



Left

Back

Front

Right

On a scale of one to ten how intense are your symptoms? Not intense ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

Health Questionnaire

Patient Information

Date: _____

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____

List all prescription, non prescription 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 anything you are allergic to: _____

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual):

Do you exercise? Yes No Hours per week _____ What activity(s)? _____

Are you dieting? Yes No Since: _____ Do you smoke? Yes No _____ packs per day.

How many years have you been smoking? _____ Do you drink alcoholic beverages? Yes No _____ drinks per day.

Do you wear? Heal lifts Arch supports Prescription Orthotics

For women: Are you pregnant or nursing? Yes No If pregnant, How many weeks? _____

Date of last menstrual period: _____

INFORMED CONSENT

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.

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. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

ANALYSIS, EXAMINATION, AND TREATMENT. As a part of the analysis, examination, and treatment, you are consenting to the following procedures (please initial):

_____ Spinal Manipulative Therapy
_____ Palpation
_____ Vital Signs
_____ Range of Motion Testing
_____ Orthopedic Testing
_____ Basic Neurological
_____ Muscle Strength Testing

_____ Postural Analysis Testing
_____ Ultrasound
_____ Hot/Cold Therapy
_____ Electrical Muscle Stimulation
_____ Radiographic Studies
_____ Other: _____
_____ **All of the above**

THE MATERIAL RISKS INHERENT IN CHIROPRACTIC ADJUSTMENT. As with any healthcare procedure, there are certain complications which may arise during spinal manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. 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 contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

PROBABILITY OF THOSE RISKS OCCURRING. Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking 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 also generally described as rare.

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-inflammatory, muscle relaxants and pain-killers; hospitalization; and/or surgery. If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

RISKS AND DANGERS ATTENDANT TO 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.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with **Dr. Sharon Bruce** 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 that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ Patient's signature (Guardian if a minor) _____ Date

_____ Doctor's Signature _____ Date

_____ Patient's Printed name

_____ Doctor's Printed Name

Financial Policy Insurance Coverage

Welcome to **The Lumbar Yard**. Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the beneficiary to pay co-insurance, co-payment and/or a deductible. For example: if you have a deductible of \$100, and your insurance pays 80%, you are responsible for 20% of all charges incurred during the year after you have paid your \$100 at the beginning of the year. Our clinic will call your insurer to verify your benefits, however, we are not responsible for your insurer's final payment and benefit determinations.

Payments

In order to help you determine your responsibility toward payment for services, please read the following, and initial your preference for the method of payment of your account. Please notify this office if the status of your insurance changes.

Private Pay: (please initial)

A ____ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

B ____ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

Health Insurance: (please initial)

C ____ I would like this clinic to bill my insurance. I understand I am responsible for the costs of treatment.

Missed Appointments

It is the policy of **The Lumbar Yard** to assess a **\$10** missed chiropractic visit fee and a **\$45** missed massage visit fee to patients who cancel appointments with less than a 24-hour notice. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others.

_____ My initials here indicate that I understand the above missed visit policy.

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.

Patient's signature

Date

Sharon D. Bruce, DC, DACBSP
The Lumbar Yard

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record

NOTICE TO PATIENT

We required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name: _____ Date of Birth: _____

I acknowledge that I have received and had the opportunity to review the Notice of Privacy Practices on the date below on behalf of The Lumbar Yard.

I understand that the Notice describes the uses and disclosures of my protected health information by The Lumbar Yard and informs me of my rights with respect to my protected health information.

Patient's Signature or that of Legal Representative

Printed Name of Patient or that of Legal Representative

Date

If Legal Representative, Indicate Relationship

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- Communications barriers prohibited obtaining the acknowledgement
- Other (please specify): _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual’s office instead of the individual’s home.

I wish to be contacted in the following manner (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Home Telephone _____
<input type="checkbox"/> O.K. to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only
<input type="checkbox"/> Work Telephone _____
<input type="checkbox"/> O.K. to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication
<input type="checkbox"/> O.K. to mail to my home address
<input type="checkbox"/> O.K. to mail to my work/office address
<input type="checkbox"/> O.K. to fax to this number
<input type="checkbox"/> Other _____
_____ |
|--|---|

Patient’s Signature

Date

Patient’s Printed Name

Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
 (2) Type key: T = Treatment records, P = Payment Information; O=Healthcare Operations
 (3) Enter how disclosure was made: F=Fax, P=Phone, E=Email, O=Other