Batherson Chiropractic Wellness Center

NEW PATIENT INTAKE FORM

Patient Name: _____

Emergency Contact:

Name: _____ Relationship: _____

Phone: _____

Is this due to an auto accident? ___YES ___NO

Type of accident: ___ Auto ___Workers Comp ___Home ___Other

Primary Insurance _____ ID#: _____

Primary Insured Name: _____ DOB: _____

Name and Address of other doctor(s) who have treated you for this condition:

_____

Were the following tests performed: ___ X-ray ___MRI ___CT-Scan

Welcome to Our Office!

Date: _____

Last _____ First _____ Middle Initial _____ Birth Date _____ Age _____

Address _____ City _____ ST _____ Zip _____

Phone (H) _____ (C) _____ Email _____

Occupation _____ Employer _____

Spouse's Name _____ D.O.B _____ Spouse Ph _____ Employer _____

Children's Name & Ages _____

Have you had previous Chiropractic care? ☐yes ☐no **Positive Experience:** ☐yes ☐no

Who may we thank for referring you to our office? _____ ☐Walk In ☐Google ☐MD Referral ☐Other_____

Who is your primary care physician? _____ Phone: _____ Date of last physical/exam? _____

May we update your medical doctor regarding your treatment in our office? ☐yes ☐no

WHAT BRINGS YOU TO OUR OFFICE? **Please provide as much detail as possible.**

Current Complaint: _____ Date when symptom first appeared _____

How Did it begin: _____

How often do you experience these symptoms? ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare10%

Have you ever experienced the same or similar symptoms? ☐yes ☐no When? _____

Have you been to another doctor for this problem? ☐yes ☐no Who/Where? _____

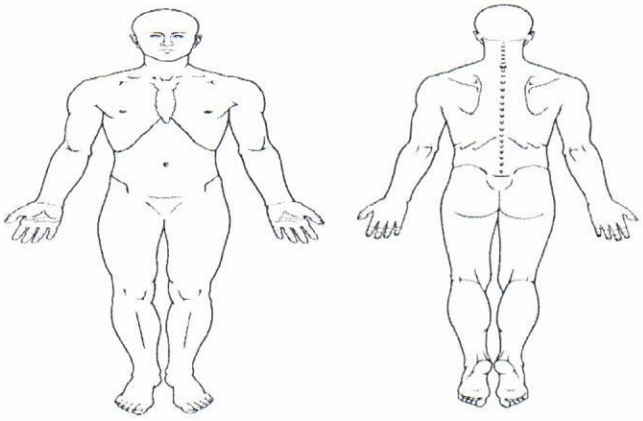
Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb ☐Other Do you have Numbness or Tingling? ☐yes ☐no Where? _____

Does the Pain Radiate into: ☐Arm ☐Hand ☐Leg ☐Foot ☐Other _____ ☐Does not radiate

What makes the symptoms increase? _____ What relieves the symptoms? _____

Drugs you now take: ☐Nerve Pills ☐Pain Pills ☐Muscle Relaxer ☐Blood Pressure ☐Other: _____

Do any family members suffer from the same complaint? If so, who?_____



Please mark off all areas of complaint on the diagrams with the following indicators:

AAA=ache DDD=dull NNN = numbness
TTT= tingling BBB= burning SSS=sharp/stabbing
XXX = other

Please rate the intensity of your symptoms on a scale of 0-10 (0 being no symptoms, 10 being extreme)

0 ◇◇◇ 1 ◇◇◇ 2 ◇◇◇ 3 ◇◇◇ 4 ◇◇◇ 5 ◇◇◇ 6 ◇◇◇ 7 ◇◇◇ 8 ◇◇◇ 9 ◇◇◇ 10

Have you ever been in an auto accident? ☐Past Year ☐Past 5 Years ☐Over 5 Years ☐Never

Please describe: _____

Please list ALL surgeries, injuries, accidents, falls, etc: _____

_____

List all Medications/Vitamins: _____

Do you smoke? ☐yes ☐no If yes, how many packs per week?_____ Have you ever smoked in the past? ☐yes ☐no When did you quit?_____

Do you consume alcohol? ☐yes ☐no If yes, how many drinks per week? _____

Do you consume caffeine? ☐yes ☐no If yes, how many drinks per day? _____

Do you exercise? ☐yes ☐no If yes, how many times per week and what type? _____

Do you have a high stress level? ☐yes ☐no If yes, list reasons: _____

Name: _____
Date: _____

Is there any possibility that you may be pregnant? □yes □no Date of Last Menstrual Cycle _____

Health History - Please circle all that apply

AIDS/ HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Asthma	Bleeding
Breast Lump	Bronchitis	Bulimia	Cancer	Cataracts	Chicken pox	Depression	Diabetes
Emphysema	Epilepsy	Fractures	Glaucoma	Goiter	Gonorrhea	Gout	Heart dx
Hepatitis	Hernia	Herniated disc	Herpes	High Cholesterol	Kidney dx	Liver dx	Measles
Migraines	Miscarriage	Mono	M. S.	Mumps	Osteoporosis	Parkinson's	Polio
Pacemaker	Pneumonia	Prostate	Prosthesis	Implants	Rheumatoid	Stroke	Thyroid
Tonsillitis	Tuberculosis	Tumors	Typhoid	Ulcers	V. D.	Whooping Cough	
Chronic Fatigue	High Blood Pressure		Fibromyalgia	Other_____			

Family History – List any diseases and conditions that are current health problems of family members.

_____

CHIROPRACTIC INFORMED CONSENT TO TREAT

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, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not. I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are 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, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and 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 above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. Initial_____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law. Initial_____

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Batherson Chiropractic Center will prepare any necessary reports and forms to assist me in making collection from the insurance company. I authorize payment of insurance benefits directly to Batherson Chiropractic Center. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, and/or payors to secure the payment of benefits. However, I clearly understand that I am personally responsible for all costs of treatment rendered, regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

Batherson Chiropractic and Wellness

Financial Policy

At Batherson Chiropractic we are committed to providing you with the highest quality medical care. This goal is best achieved if everyone is aware of our policies. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

For your initial visit and every 6 months you are required to provide us with the following:

- Photo ID (initial visit only)
- Insurance Card
- Patient information Packet

Appointment cancellation and No Show Policy: Missed appointments are very disruptive to our office and deprive others from an appointment to see the doctor.

Appointments not cancelled 24 hours prior to scheduled appointment will result in a $45.00 fee.

Insurance: We participate in most insurance plans, including Medicare. If you are not insured by a plan we are contracted with, payment in full is expected at each visit. If you are insured by a contracted plan and we are unable to verify your eligibility you will be required to pay in full for services until you provide updated insurance information to us. As a courtesy, our office will verify your insurance coverage prior to your appointment if you provide all the necessary information at least 2 days prior to your appointment. Knowing your insurance benefits are your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Insurance Changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive the maximum benefits.

Co-payments, Deductibles and Co-insurance- All payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, deductibles and co-insurance from patients can be considered fraud.

Non-Covered Services: Please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at time of visit.

Claim Submission: Batherson Chiropractic and Wellness will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Failure to provide our office with your most updated contact information and insurance details in a timely manner may result in the patient having to pay for these services at that time or being billed at a later date. Any balance remaining following adjudication of the claim is your responsibility. This balance may include deductible, co-pay, co-insurance or any and all charges not covered by your insurance company.

Patient balances and past due accounts: Patient balance is due upon receipt of your billing statement. After the second statement is sent, a $5.00 fee will be added to your unpaid balance. This fee will be assessed monthly until your outstanding balance is resolved. Our office will make every effort to communicate with you about your account. Any returned checks will result in a $35.00 fee that will be posted to your account.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

Revised 8/22/16