CORE FAMILY CHIROPRACTIC

ADULT INTAKE FORM

Date: _____

PERSONAL INFORMATION

First Name: _____ M.I.: _____ Last Name: _____

Preferred Name: _____ Social Security Number: _____

Address: _____

City / State / Zip: _____

Cell Phone: ( ) _____ Alternate Phone: ( ) _____

Text Reminders: Y N Before Appointment: 1 hr 4 hrs 1 day

Email: _____ *(For updates on office hours, events, etc.)*

Birth Date: _____ Age: _____ Sex: M F

Occupation: _____ Employer's Name: _____

Marital Status: S M D W Other Spouse's Name: _____

# of Children: _____

Children's Names & Ages: _____

Who can we thank for referring you or how did you hear about CORE Family Chiropractic? _____

_____

REASON FOR SEEKING CARE

What is your reason for seeking care at CORE Family Chiropractic? _____

_____

When did this begin? (If applicable) _____

Are there any major injuries and/or surgeries we should know about? _____

_____

What is this affecting that is MOST important in your life? (List all that apply)

_____

Have you seen any other providers for this condition? (List all that apply)

_____

Have you seen a chiropractor before? Yes No

How long ago? _____ Clinic/Doctor Name: _____

What is your reason for the change? (If applicable) _____

What is your level of commitment to yourself and your health? 1 2 3 4 5 6 7 8 9 10

Explain: _____

What health goal, if you were to complete or accomplish it, would have the greatest impact on your life?

_____

_____

HEALTH CONCERNS

- ☐ Anxiety/Depression
- ☐ Digestive Troubles
- ☐ Nausea/Vomiting
- ☐ Diabetes
- ☐ Hypertension
- ☐ Arthritis
- ☐ Loss of Balance
- ☐ Neck/Back Pain
- ☐ Pain in Arms/Legs
- ☐ Irritabilty
- ☐ Fatigue/Sleep Issues
- ☐ Dizziness
- ☐ Ringing in Ears
- ☐ Sensitivity to Light
- ☐ Loss of Concentration
- ☐ Memory Problems
- ☐ Headaches
- ☐ Stiffness/Flexibility
- ☐ Sinus Troubles/Allergies
- ☐ Cold Hands/Feet
- ☐ Other _____

Explain any boxes checked above or add additional concerns:

_____

_____

_____

_____

_____

Is there anything else regarding your current condition you feel the doctor should know?_____

_____

_____

MEDICATIONS

- ☐ Anxiety/Depression
- ☐ Blood Pressure
- ☐ Pain Narcotics
- ☐ Muscle Relaxers
- ☐ Migraine/Headache
- ☐ Cholesterol
- ☐ ADD/ADHD
- ☐ Diabetes
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Explain any boxes checked above: _____

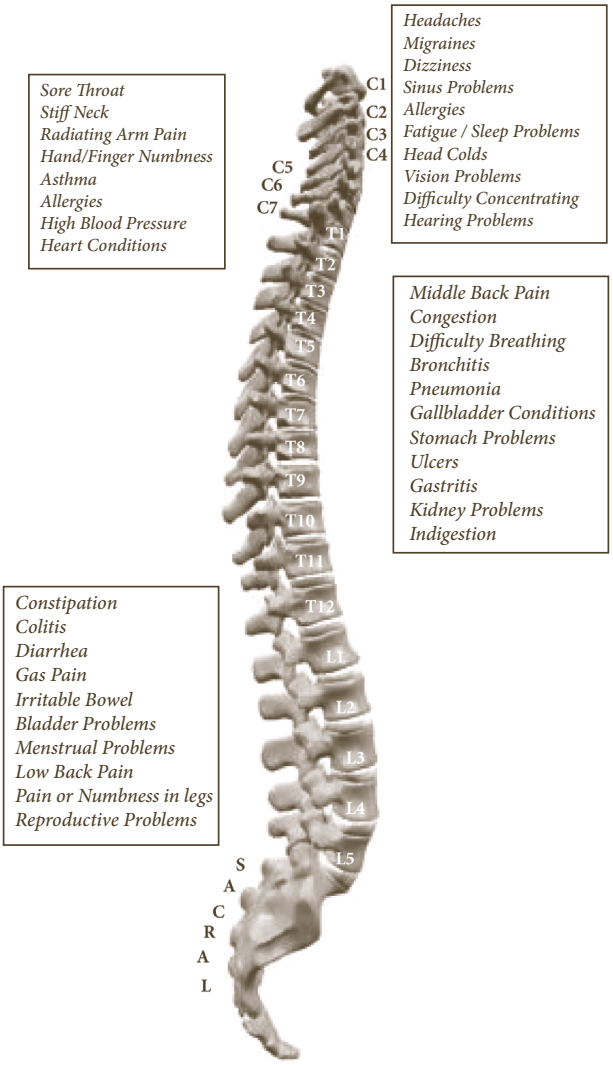
_____

_____

_____

Did You Know...

Each health concern relates to a specific area of the spine and nervous system? Please circle below or enter the information to the left.



VITAMINS / SUPPLEMENTS

- ☐ Multi-Vitamin
- ☐ Vitamin D3
- ☐ _____
- ☐ _____
- ☐ Fish Oil/Omega-3
- ☐ Probiotics
- ☐ _____
- ☐ _____

Explain any boxes checked above:

_____

_____

_____

EMERGENCY CONTACT

First Name: _____ M.I.: _____

Last Name: _____

Preferred Name: _____

Address:_____

City / State / Zip: _____

Phone: ( ) _____Relation: _____

Most life stresses can be grouped into 3 main categories: Physical, Chemical, and Emotional Stress.
Please check any of the following stresses you experience on a regular basis.

Physical Stress

☐ Physical Pain ☐ Low Energy/Fatigue ☐ Job/Hobbies Cause Discomfort ☐ Tightness/Stiffness
☐ History of Accidents/Injuries ☐ Inability to Exercise/Perform Physical Activities ☐ Other _____
Explain: _____

_____

_____

Chemical Stress

☐ Fast Food/Highly Processed Food ☐ Medications (Prescription or OTC) ☐ Consume Alcohol ☐ Tobacco
☐ Amalgam Fillings ☐ Makeup/Lotion/Other Skin Products ☐ Other _____
Explain: _____

_____

_____

Emotional Stress

☐ Work/Job ☐ School ☐ Health ☐ Finances ☐ Family ☐ Daily Schedule/Time ☐ Other _____
Explain: _____

_____

_____

What else about your health or your life do you feel is important for the doctor to know?

_____

_____

_____

_____

Patient Consent to X-Ray

I authorize the performance of x-ray examination, which CORE Family Chiropractic may consider necessary or advisable in the course of my examination and treatment.

Signed:_____ Date: _____

X-Ray Consent for Women of Childbearing Age

This is to certify that, to the best of my knowledge, I am not pregnant, and CORE Family Chiropractic has my permission to perform diagnostic x-ray examination. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed:_____ Date: _____

For Office Use Only

ID#: _____ V:_____

Films:_____ P: _____

ROF: _____ A:_____

Other _____

PATIENT HIPAA CONSENT FORM

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view charges to your records. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand

your Notice of Privacy Practices. I also understand that I can request in writing that you restrict how my personal information is used and disclosed.

Date: _____ Print Patient Name:_____

Signature:_____

FINANCIAL POLICY

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

- Payment for services is due upon receipt.
- We urge our patients to follow the doctors' recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, care must be followed.
- I authorize CORE Family Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement charges incurred by me.
- Chiropractic care in this office deals with vertebral subluxation, and will therefore be billed according to diagnostically appropriate procedural codes. While we will provide an itemized receipt upon your request, we anticipate that care will not be reimbursed by a third party carrier. This does not apply to PI, WSI, or Medicare. HSA and FLEX spending accounts may be utilized.
- I authorize the direct payment to CORE Family Chiropractic of any sum I now or hereafter owe by my attorney out of settlement of my case, and by any insurance company obligated to make payment to me or CORE Family Chiropractic based in whole or in part upon the charges made for services received. I hereby appoint CORE Family Chiropractic authority to endorse and cash checks, drafts, or money orders made payable to the undersigned or as co-payee with this clinic or payments due for services rendered on behalf of the undersigned by CORE Family Chiropractic.
- If you have any questions about our financial policies, please ask our staff. If you need to make special arrangements, please ask. We will do everything possible to meet your financial needs.
- *Advanced Beneficiary Notice of NON-Coverage (ABN).* Your health insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your health insurance will not pay for items and services such as your initial visit and any chiropractic care deemed maintenance or wellness care by your carrier (as well as other items that may arise in the future). Signing below signifies that you want these items and services, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. This notice gives our opinion, not an official Medicare or other insurance carrier's decision. If you have other questions, please ask our staff. Signing below means that you have received and understand this notice.

Date: _____ Signature : _____

AUTHORIZATION FOR CARE

I hereby authorize the doctors and staff at CORE Family Chiropractic to treat my condition as deemed appropriate. At CORE Family Chiropractic, we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctors/clinic will not be held responsible for any pre-existing medical conditions. I certify that the above information is correct to the best of my knowledge. I will not hold the doctors or any staff member of CORE Family Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic, as well as all other types of health care is associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Date: _____ Signature: _____

Advanced Beneficiary Notice (ABN)

The purpose of this form is to help you be aware of chiropractic services in this office as it relates to any medical insurance you may have. Chiropractic care in this office is not focused on diagnosis of or relief of symptoms; it is centered on the location, analysis, and correction of underlying vertebral subluxations. Because of this, all services are coded in a manner which insurance carriers view as maintenance or wellness care and most likely will not be covered. Signing below signifies that you want the services provided in this office, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. This notice gives our opinion and policies as it relates to insurance coverage, not an official Medicare or other insurance carrier's stance or decision. Signing below indicates you have received and understand this notice.

Date: _____

Name (Printed): _____

Signature: _____

Parent/Guardian Signature (if applicable) _____