

INSPIRED FAMILY CHIROPRACTIC NEW PATIENT INTAKE

Today's Date: _____

HRN: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____-____-____ Age: ____ Male Female

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

E-mail Address: _____ Home Phone: _____ Mobile Phone: _____

Marital Status: Single Married Do you have Insurance: Yes No Work Phone: _____

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Name & Number of Emergency Contact: _____ Relationship: _____

Whom may we thank for referring you to this office? _____

HISTORY of COMPLAINT

What is your reason for today's visit? Please expand below ...

Spinal Check-up / Wellness evaluation I have pain or another symptom (please describe)

When did the problem begin? _____

Is your pain dull or sharp? Does it radiate anywhere? _____

How did the injury happen? _____

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

What relieves your symptoms? _____

What makes your symptoms feel worse? _____

Other forms of treatment tried: No Yes **If yes, please state what type of treatment:** _____,
Who provided it: _____ **How long ago?** _____

Have you seen a Chiropractor before? No Yes If yes, who & when? _____

What were the results? Favorable Unfavorable → please explain:

List any medications you are taking: _____

_____ N/A or None.

On a scale of 1-10 how bad is it at its worst? (1= Slightly Painful & 10= Very Painful)

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

Please circle all symptoms you have ever had, even if they do not seem related to your current problems.

Headaches	Pins and Needles in legs	Fainting	Neck Stiffness
Pins and Needles in arms	Loss of smell	Back Pain	Loss of Balance
Dizziness	Ringing in ears	Ringing in ears	Nervousness
Numbness in fingers	Numbness in toes	Loss of taste	Stomach upset
Fatigue	Depression	Irritability	Tension
Sleeping problems	Neck Pain	Cold hands	Cold feet
Cold Sweats	Constipation	Fever	Hot flashes
Mood Swings	Lights bother eyes	Problem urinating	Heartburn
	Menstrual Pain	Menstrual irregularity	Seizures

Please indicate if you have ever been diagnosed with any of the following conditions:

Tumors No Yes Cancer No Yes Heart Attack No Yes Diabetes No Yes
Rheumatoid Arthritis No Yes Osteo Arthritis No Yes Cerebral Vascular No Yes

Any other medically diagnosed conditions? _____ N/A or None.

Does anyone in your family have any medically-diagnosed conditions (If so, whom)?: _____
_____ N/A or None.

List any surgical operations and year they were performed: _____

List any broken bones / fractures or dislocations you have had: _____

SOCIAL HISTORY

1. **Smoking:** cigars pipe cigarettes How often? Daily Weekends Occasionally Never

2. **Alcoholic Beverage:** consumption occurs Daily Weekends Occasionally Never

3. **Recreational Drug use:** Daily Weekends Occasionally Never

4. **Hobbies -Recreational Activities- Exercise Regime:** Is this condition interfering with any of the following?

Work	<input type="checkbox"/>	Sleep	<input type="checkbox"/>	Recreation	<input type="checkbox"/>	Sports/Exercise	<input type="checkbox"/>
Self-care	<input type="checkbox"/>	Energy	<input type="checkbox"/>	Attitude	<input type="checkbox"/>	Patience	<input type="checkbox"/>
Creativity	<input type="checkbox"/>	Productivity	<input type="checkbox"/>	Relationships	<input type="checkbox"/>	ADL's	<input type="checkbox"/>

Other: _____

I hereby authorize payment to be made directly to Inspired Family Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Inspired Family Chiropractic for any and all services I receive at this office.

Patient or Guardian Signature

____ - ____ - ____
Date Completed

Doctor's Signature

____ - ____ - ____
Date Form Reviewed

Inspired Family Chiropractic
18635 Soledad Canyon Rd, Suite 102. Santa Clarita, CA. 91351

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. **The fee for copying your x-rays is \$25.00. This fee must be paid in advance.**

Digital x-rays on cd will be available within 72 hours of prepayment on any regular practice hour day. Please note: x-rays are utilized in this office to help locate and analyze **vertebral subluxations**. These x-rays are not used to investigate for medical pathology. The doctors of Inspired Family Chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

BY SIGNING BELOW, YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

PRINT YOUR NAME HERE

DATE

SIGNATURE

YOUR AGE

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT INSPIRED FAMILY CHIROPRACTIC.

SIGNATURE

DATE

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Release of Information: Your Protected Health Information (PHI) will be used by this office and/or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the Privacy Practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information: You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent: You may revoke this consent to the use and disclosure of your PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I, _____ (print) acknowledge that I have reviewed the above information and I authorize this office to release information concerning my condition and treatment to my insurance company, attorney, insurance adjuster and/or other health care providers deemed necessary for treatment purposes, processing my claim, benefits and payment of services rendered to me as well as coordinated treatment. I do understand that if I choose to refuse release of this information, that my PHI will be used **within** the office for purposes of my care, to those individuals designated by the doctor.

Patient or Guardian Signature: X _____ Date: _____

Informed Consent for Treatment

I hereby request and consent to the performance of chiropractic procedures, various forms of physio-therapy, physical examination, x-ray studies, and/or any clinical services that are deemed necessary in my case to be administered by the doctor and/or any support staff employed or contracted by this office or clinic. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as "rare" and include, but are not limited to, muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fracture, disc injury, stroke, dislocations and sprains.

I understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also be used to alleviate other symptoms through a conservative approach with hopes to avoid more invasive procedures. I further understand that, as with all healthcare treatments, results are not guaranteed and there is no promise to cure. I hereby acknowledge that if I do not keep appointments as recommended to me by my treating doctor, he/she has the right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. I further understand that there are other treatment options available for my condition, and that I have the right to a second opinion should I have concerns as to the nature of my symptoms and/or treatment options. If during the course of my care my insurance company requires me to take an examination from any other doctor, I will notify this facility/physician immediately. I understand that failure to do so may jeopardize my case.

I, _____ (print) have read the above consent and I have had an opportunity to ask questions regarding its content. By signing below, I agree to the above-named procedures and intend this consent to cover my entire course of treatment for my present condition and for any future condition(s) for which I seek treatment with this office.

Patient or Guardian Signature: X _____ Date: _____

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

- A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
- B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
- C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day doctors of chiropractic in the United States alone.
- D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
- E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
- F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic
- G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

Signature

Date

Insurance Policies and Fee Schedule

- o **Consultation**- includes practice member history. This service is complimentary
- o **Assessment (new or established practice member)**- includes one or more of the following: thermography, surface electromyography, range of motion, motion and/or static palpation, leg check \$60-\$80.
- o **Chiropractic Adjustment**- The actual re-alignment of the vertebra done by hand. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. \$50-\$65.
- o **X-rays**- Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after period of care. \$50 per view.

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Nicole Platte DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Signed _____

Date _____