HAND CRAFTED
CHIROPRACTIC

Confidential Patient Intake Information

Today's Date_____

These forms are legal documents and are necessary to bill insurance and are part of your medical chart. They must be completed in detail so please take your time and ask for assistance if you need help.

First and Last Name_____

Address_____

Apt/Ste/Unit#_____ City_____

Zip Code: _____

Home Phone_____ Cell Phone_____

Work Phone_____ Email _____

Sex: ○ M ○ F / Marital Status: ○ S ○ M ○ W ○ D / Number of Children _____

Date of Birth _____ Social Security # _____

Driver's License # _____

Occupation _____

Employer _____

Spouse's Name _____

1. Is this condition the result of an injury that happened at work? Y_____ N_____
2. If yes, did you report it to your supervisor? Y____ N_____
3. Is your condition the result of auto accident? Y____ N_____
4. Who referred you to our office? _____
5. How do you wish to receive appointment reminders? ○ Phone ○ Email

I understand and agree that health insurance policies are an arrangement between my insurance carrier and myself. I understand that ***Hand Crafted Chiropractic*** *will prepare my billings to assist me in making collections from the insurance company.*
I clearly understand and agree that I am responsible for the payment of all services rendered to me if my insurance company, for whatever reason, does not pay for treatments rendered to me.
I also understand that if I terminate my care, any professional fees for services will become due and payable.

_____ _____

Patient's / Guardian Signature **Today's Date**

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PRESENT COMPLAINT(S)

Please check description boxes and fill in the blanks in the appropriate space below. Please describe the present complaint(s) that brought you to this clinic for care. After completing this first section, please complete the questionnaire on the reverse side.

1. What is the main complaint? When did it begin, and what do you believe caused it?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

2. Any previous episodes of the same condition? ☐ Yes ☐ No

3. Please describe the quality of your pain (check all that apply): ☐ Sharp/Stabbing ☐ Sharp ☐ Dull ☐ Achy ☐ Sore ☐ Weakness ☐ Throbbing ☐ Numbness ☐ Shooting ☐ Gripping/ Constricting ☐ Burning ☐ Tingling

3. How often are the complaints present? ☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Occasional (26-50%)

4. Please indicate the severity of your pain or ache. (0 being no pain and 10 being the worst pain you've ever felt)

0 1 2 3 4 5 6 7 8 9 10

5. Since your problem began is the pain: ☐ Increasing ☐ Decreasing ☐ Not Changing

6. What treatments have you received for this present condition? ☐ Previous Chiropractor ☐ Physical Therapy ☐ Spinal Injections ☐ Surgery ☐ Back Support ☐ Medication ☐ No Care ☐ Other (specify below)

_____

7. What activities or positions help relieve your pain? ☐ Chiropractic Care ☐ Ice ☐ Heat ☐ Laying Down ☐ Walking ☐ Sitting ☐ Standing ☐ Movement/Exercise ☐ Massage ☐ Nothing Helps ☐ Other (specify below)

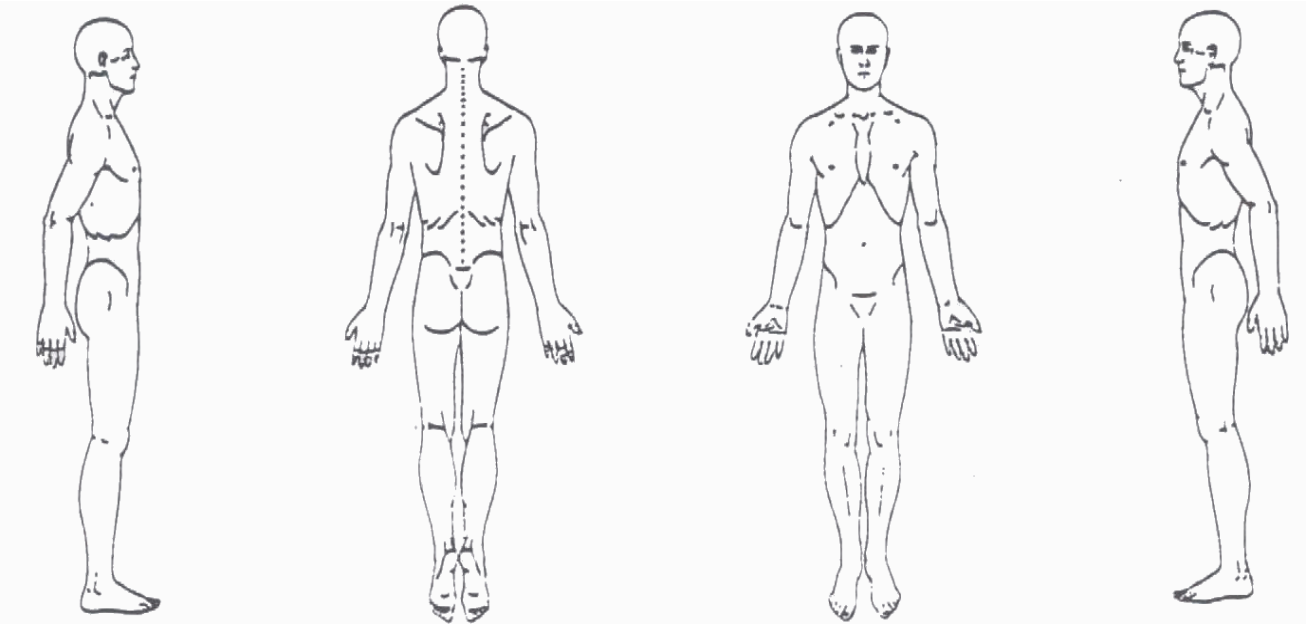
_____

8. What activities or positions increase your pain? ☐ Coughing or Sneezing ☐ Taking a Deep Breath ☐ Bending ☐ Walking ☐ Sitting ☐ Standing ☐ Movement/Exercise ☐ Inactivity ☐ Nothing helps ☐ Other (specify below)

_____

9. Are your complaints affecting your ability to work or otherwise be active? ☐ No effect ☐ Some physical restrictions ☐ Need limited assistance with common everyday tasks ☐ Need assistance often ☐ Have a significant inability to function without assistance ☐ Completely disabled (impaired) cannot care for self.

Mark an X below where you have pain or other symptoms, include radiation (movement) of pain, numbness, or tingling with an arrow



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Past and Present Medical History

If you have ever had a listed symptom in the past; please check that symptom in the *Past* column. If you are presently troubled by a particular symptom, check that symptom in the *Present* column.

Past	Present	*Condition*
☐	☐	Neck Pain
☐	☐	Shoulder Pain
☐	☐	Pain in Upper Arm or Elbow
☐	☐	Hand Pain
☐	☐	Wrist Pain
☐	☐	Upper Back Pain
☐	☐	Low Back Pain
☐	☐	Pain in Upper Leg or Hip
☐	☐	Pain in Lower Leg or Knee
☐	☐	Pain in Ankle or Foot
☐	☐	Jaw Pain
☐	☐	Swelling of Joints (Specify Joints)
☐	☐	Stiffness of Joints (Specify Joints)
☐	☐	Fainting
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Headache
☐	☐	Muscular Coordination Abnormalities
☐	☐	Tinnitus (Ringing in Ears)
☐	☐	Rapid Heart Rate
☐	☐	Chest Pains
☐	☐	Loss of Appetite
☐	☐	Abnormal Weight Gain
☐	☐	Abnormal Weight Loss
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis

Past	Present	*Condition*
☐	☐	Menopausal Symptoms
☐	☐	Painful Urination
☐	☐	Loss of Bladder Control
☐	☐	Loss of Bowel Control
☐	☐	Frequent Urination
☐	☐	Abdominal Pain
☐	☐	Difficulty in Swallowing
☐	☐	Heartburn/Indigestion
☐	☐	Constipation
☐	☐	Rash
☐	☐	Dermatitis or Eczema
☐	☐	HIV

Please check all of the following that apply to you

☐	☐	Tobacco
☐	☐	Alcohol use
☐	☐	Medications (please list)_____
☐	☐	Drug or Alcohol Dependence
☐	☐	Pregnancy
☐	☐	Surgical Procedures (please list) ___

Listed below are common disease and disorders. Please indicate whether you have had a particular disorder in the past or are presently troubled by a listed disorder.

Past	Present	*Condition*
☐	☐	Depression
☐	☐	Aortic Aneurysm
☐	☐	High Blood Pressure
☐	☐	Angina
☐	☐	Heart Attack
☐	☐	Stroke
☐	☐	Asthma
☐	☐	Cancer
☐	☐	Prostate Illness
☐	☐	Anorexia/Bulimia

Past	Present	*Condition*
☐	☐	Emphysema: Chronic lung disorders
☐	☐	Arthritis
☐	☐	Diabetes
☐	☐	Ulcer
☐	☐	Kidney Stones
☐	☐	Bladder Infection
☐	☐	Kidney Disorders
☐	☐	Other _____
☐	☐	_____

Patient's Signature: _____ **Date**: _____

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Informed Consent for Chiropractic Care

Please read the entire document prior to signing it. It is important that you understand the information contained herein. Please ask questions before you sign if there's anything that is unclear.

The Nature of The Chiropractic Adjustment

The primary treatment we use as Doctor of Chiropractic is spinal manipulative therapy. We may use our hands or a mechanical instrument in such a way as to move your joint. This may cause an audible sound and you may also feel a sense of movement.

Analysis / Examination / Treatment

I authorize the doctors of Hand Crafted Chiropractic / Greenberg Swaffer Chiropractic Corporation to administer such care that is necessary for my case. This care may include consultation, examination, adjustments, and/or any other procedure that is advisable and necessary for my healthcare. I further understand that a fee for service rendered will be charged and that I am responsible for the fee regardless of the results.

Material Risks Inherent with Chiropractic Adjustments

As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation and therapy. These complications include but are not limited to headaches, muscle strains, disc injuries, stroke, dislocation, fractures, myelopathy, and separations. Some patients will feel some stiffness and soreness following the first few days of treatment. The doctors at Hand Crafted Chiropractic 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 the doctor's attention, it is your responsibility to inform the doctor.

The risk of injuries or complications from Chiropractic treatments are substantially lower than that associated with many medical or other treatments, medication, and surgical procedures given for the same treatment.

The Availability and Nature of Other Treatment Options

Alternatives to chiropractic treatments include medication's, physical therapy, other medical treatments, and surgery provided by physicians and surgeons. If you have any questions regarding other treatment options, the doctor will be happy to discuss them with you.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I, _____ (Patient/Guardian Name) have read the above explanation of the chiropractic adjustment and related treatment. I understand the potential risks, and hereby give my consent to chiropractic treatment.

Signature_____
Date_____

Consent to Treat a Minor

I, _____am the parent or legal guardian of _____(Child). I have read and understand the above explanation of treatment, I understand the potential risks, and I hereby grant permission for my child/children to receive chiropractic care

Signature of Parent/Guardian_____
Date_____

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Notice of Privacy Practices & HIPPA

This notice of privacy practices and authorizes Hand Crafted Chiropractic / Greenberg Swaffer Chiropractic Corporation to use and/or disclose protected healthcare information in accordance with the following specific authorizations:

- I give permission to Hand Crafted Chiropractic Corporation / Greenberg Swaffer Chiropractic Corporation to use my name, address, phone numbers, and clinical records to contact me with health-related emails and information about treatment alternatives or other health related information.

We understand that medical information about your health is personal, and we are committed to protecting this information. When you receive Chiropractic treatment from Hand Crafted Chiropractic / Greenberg Swaffer Chiropractic Corporation, a record of the treatment you receive typically contains treatment plan, your history and physical exam, any x-ray/test results you provide us, and billing record. This record serves as the basis for planning your treatment and a tool for assessing ways to improve the care rendered.

We are required by law to:

1. Maintain privacy and security of your medical information.
2. Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you.
3. Abide by the of terms of this notice.

We may use and disclose medical information about you for purposes related to treatment, payment, health care operations, contacting you, appointment reminders, as required by law, health oversight activities, lawsuits and disputes, law-enforcement with court order/subpoena, and electronic disclosure.

Your rights regarding your medical information:

1. Right to inspect and copy.
2. Right to amend.
3. Right to an accounting of disclosures.
4. Right to request restrictions.
5. Right to revoke an authorization.
6. Right to receive a copy of this document.

We reserve the right to change our practices and to make new provisions effective for all medical information we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may contact us if you wish to request a copy of Hand Crafted Chiropractic / Greenberg Swaffer Chiropractic Corporation Notice of Privacy Practices.

I understand and have been provided with a notice of information practices that provide me a more complete description of information uses and disclosures. I understand my rights and privileges. By signing the following I am giving Hand Crafted Chiropractic / Greenberg Swaffer Chiropractic Corporation permission to use and disclose my protected health information in accordance with the directives listed above.

Signature of Patient or Legal Guardian: _____ Date_____

Terms and Conditions

Please initial the following:

1. **Personal Information Updates:**

   _____ Patient agrees to timely notify Hand Crafted Chiropractic of any changes in the patient's personal information, including mailing address, insurance policy, telephone number, and credit/debit card information. We reserve the right to suspend services while such information is pending from the patient.

2. **Personal Belongings:**

   _____ I understand that Hand Crafted Chiropractic is not responsible for lost or stolen articles or goods.

3. **Payment Policy:**

   _____ A valid credit or debit card will be kept on file. Payment is required at the time services are rendered.

4. **Appointment Cancellations:**

   _____ I agree to notify Hand Crafted Chiropractic at least 24 hours in advance if I need to cancel a scheduled appointment. I understand that failure to provide timely notice may result in a fee of $50.00 for missed or canceled 30-minute follow-up appointments, radial pressure wave therapy, or decompression therapy sessions, and $75.00 for missed or canceled 60-minute appointments. These fees will be charged to my account.

5. **Dispute Resolution:**

   _____ In the event of any dispute, controversy, or claim arising out of or relating to these Terms and Conditions, the agreement, your treatment, or the services received at Hand Crafted Chiropractic / Greenberg Swaffer Chiropractic Corporation (S-Corp), you, as the patient, understand and agree that both parties will first attempt, promptly and in good faith, to resolve the dispute through mediation. Failure by you, the patient, to deliver a formal mediation notice prior to initiating a legal claim or lawsuit will serve as prima facie evidence for Hand Crafted Chiropractic / Greenberg Swaffer Chiropractic Corporation (S-Corp) to seek a motion to dismiss the lawsuit. If the parties are unable to resolve the dispute through mediation within a reasonable time (not to exceed 60 days), the dispute shall be resolved exclusively through binding arbitration before the American Arbitration Association, under its then-current consumer arbitration rules, unless otherwise mutually agreed by the parties. Any arbitration between you and Hand Crafted Chiropractic / Greenberg Swaffer Chiropractic Corporation (S-Corp) will take place in Huntington Beach, California, and will be conducted on an individual basis. By agreeing to arbitration, you understand and agree that you are waiving certain legal rights, including the right to sue in court, the right to have the dispute decided by a judge or jury, and the right to participate in a class action lawsuit.

6. **Explanation of Insurance Coverage:**

   _____ Your insurance policy is a contract between you and your insurance company. As a courtesy, we will submit claims to your insurance provider for services rendered in this office. However, payment of any deductibles (if not yet met), copayments, and any remaining balance after insurance payment is your responsibility. Your copay is due at the time of service. Additionally, you are responsible for any portion of your bill that exceeds the coverage limits of your insurance policy.

7. **Assignment of Benefits:**

   _____ By signing this form, you authorize that all medical benefits payable under your insurance policy for services rendered by this office will be made directly to Hand Crafted Chiropractic (Greenberg Swaffer Chiropractic Corporation). If your insurance carrier sends any payments directly to you for services provided by this office, you agree to forward those payments to our office immediately upon receipt. All payments issued to you by your insurance carrier must be forwarded to Hand Crafted Chiropractic and endorsed on the back with the statement, "Pay to the order of Greenberg Swaffer Chiropractic Corporation." Alternatively, you may submit a personal check for the exact amount of the insurance payment. If doing so, please include a copy of the Explanation of Benefits (EOB) to ensure proper application of your payment to the relevant date of service. This payment, along with all corresponding EOBs, is due within fifteen (15) days of receipt. If payment is not received from your insurance carrier within 15 days, the outstanding balance will be automatically charged to the payment method we have on file for you.

Signature of Patient or Legal Guardian: _____ **Date**: _____