

Chiropractic Intake Form



ID: _____

PATIENT:

Last Name: _____ First Name: _____ Middle: _____
 Address: _____ Apt: _____
 City: _____ State: _____ Zip Code: _____
 Home #: _____ Work #: _____
 Cell #: _____ Other #: _____
 Marital Status: _____ Single _____ Married _____ Domestic Partner _____ Divorced _____ Widow/er _____
 Birthdate: ____/____/____ Age: _____ Gender: _____ Male _____ Female _____ SSN: _____
 Referred by: _____ Email: _____
 Primary Care Physician's Name and #: _____ Permission to Contact: Y or N

EMPLOYER:

Employer: _____ Occupation: _____
 Address: _____ Suite: _____
 City: _____ State: _____ Zip Code: _____

SPOUSE/ GUARDIAN/ PARTNER OR EMERGENCY CONTACT:

Last Name: _____ First Name: _____ Relationship: _____
 Cell #: _____ Other #: _____

RESPONSIBLE PARTY: (Complete this section if you are not the patient but are responsible for the account)

Name: _____ DOB: _____ Relationship: _____
 Address: _____ SSN: _____
 City: _____ State: _____ Zip Code: _____
 Home #: _____ Work #: _____

☐ I, _____, give Clearwater Clinic permission to treat my minor son/daughter.

Health Insurance Portability and Accountability Act (HIPAA):

Effective Date: May 1, 2007

Clearwater Clinic is dedicated to preserving your "Protected Health Information" (PHI). We are required by law to protect your health information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information. This Notice of Privacy Practices describes your rights and Clearwater Clinic's duties with respect to your PHI. Clearwater Clinic may use or disclose your PHI for the purpose of diagnosing or providing treatment, obtaining payment for healthcare bills or to conduct health care operations.

We may be required by law to use and disclose your medical information for other purpose without your consent or authorization.

Your PHI means health information including your demographic information collected by health care providers, health care clearinghouse or an employer. This PHI relates to your past, present or future physical or mental health or condition and identifies you, or there is reasonable basis to believe the information may identify you.

You have the right to amend or correct your medical information and obtain an accounting of our disclosures of your medical information. You also have a right to request that we communicate with you confidentially, request that we restrict certain uses and disclosures of your health information, and file a complaint if you think your rights have been violated. All requests and complaints must be made in writing. We may revise our NOTICE from time to time.

Financial Policy

In the interest of good health care practice, it is desirable to establish a financial policy to avoid misunderstandings. All accounts are payable in full at the time of service. We accept cash and checks, as well as Visa and MasterCard for your convenience. A \$30 charge will be imposed for all returned checks. Any balance outstanding more than 60 days will bear interest at 18% per annum. Any missed or cancelled appointments without 24 hour notice will be charged a minimum of \$35. This will ensure keeping cost to a minimum and using treatment time effectively. Patients that pay in full at the time of service, receive a discount as a special thank you from our office.

I have read this policy and understand that **I am responsible for payment on my account**. I understand that delinquent accounts will be assigned to a credit reporting collection agency. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agree to pay for all costs and expenses, including reasonable attorney fees.

My account is (please choose one):

- ☐ *Self Pay* I will receive a 35% discount on services when I pay at the time of service.
☐ *Insurance* Please bill my insurance carrier (complete Insurance Assignment). I understand by choosing to bill my insurance **I forfeit the self pay discount**.

Signature _____

Date _____

**INSURANCE:**

Insurance Company: _____ Phone # _____

Address: _____

City: _____ State: _____ Zip Code: _____

Insured's Name: _____

Group: _____ ID: _____

Advance Beneficiary Notice (ABN)

Your insurance plan may only pay for covered items according to your plan provisions and payment policies. If your plan does not pay for a particular item does not mean you should not receive it. Your plan may cover these services elsewhere. Please inform us if there are any services your insurance will not cover and you do not want to pay for out of pocket.

Insurance Assignment and Authorization for Payment

I certify that I and/or my dependent(s) have insurance coverage with the insurance listed above and assign directly to Clearwater all insurance benefits otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.**

I authorize the use of my signature on all insurance submissions. Clearwater may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Insurance is billed as a courtesy to our patients, when you provide us with your social security number, your credit card (see below) and a copy of your insurance card. Any information that is not provided on the insurance card is the patient's responsibility to obtain. **We cannot accept responsibility for collecting from your insurance company or negotiating a disputed claim.** Insurance reimbursement is a contract between you and your insurance company. You are responsible for payment on your account.

The amount you owe will depend upon receipt of insurance payment. Unfortunately it can take 6-8 weeks for claims to be processed. Although our office understands there is a necessary waiting period while insurance processes your claim, please understand **you are still ultimately responsible for your account.** If your balance is not collected within 60 days of the date of service, payment is due from you. Any overpayments on your account will be refunded.

I authorize Clearwater to charge my credit card at 60 days for any amount my insurance has not paid.

☐ Visa ☐ MasterCard ☐ CareCredit

Card # _____

Expiration: _____ Last 3 digits on the back: _____

Signature of Patient, Guardian or representative_____
Date_____
Please print name of Patient, Guardian or representative_____
Relationship



COMPLETE THIS FORM BEFORE YOUR APPOINTMENT

Health Insurance Coverage Verification

We ask you to verify your benefits so that there are no added surprises with billing your insurance carrier. Your insurance company may make changes to your benefits without notifying you. It is for your benefit to know your insurance coverage in advance.

Name: _____

1. Call the member services phone number on your insurance card.

Automated systems will not provide complete information be sure to ask for a customer service representative.

2. State "I am calling to get my Chiropractic Benefits"

3. Today's date: _____

4. Ask for the representatives name: _____

5. Do I have in-network and out-of-network benefits? _____

6. Is my chiropractor in-network? (Bryan Baisinger or Greg Lekas) Yes or No

My benefits according to my Doctor's network status:

7. What is my effective date? _____

8. What is my deductible? _____

9. Has it been met? _____

10. If not, how much is left? _____

11. What is my co-pay/co-insurance? _____

12. Do I have a maximum dollar amount covered per year? _____

13. Do I have a maximum number of visits covered per year? _____

14. Is CPT code 97140 (myofascial work or manual therapy) covered? _____

15. Is CPT code 97110 (physiotherapy or exercise therapy) covered? _____

16. Are X-Rays covered? _____

Notes: _____

If you choose not to verify your benefits please sign here: _____



Name: _____

Date: _____

Current Symptoms:

Date Symptom(s) Started: _____

Are your symptoms from an "on job injury" or Car Accident? Yes** No

****If the answer to the above question is yes, please ask for the Personal Injury form.**

Primary Symptom: _____ Secondary Symptom: _____

Describe Onset: _____

Do you have radiating pain into your arms or legs? Yes No

What makes it better: _____

What makes it worse: _____

Pain Severity: 0 = No Pain, 10 = Worst Pain Ever. (0-10) Your Average: _____ At Worst: _____

Are your pains worse at any time during the day, if so when? AM or PM Other: _____

What types of exercise are you doing? 1. _____ 2. _____

Are you taking prescription medication? Yes No If yes, what type? _____

Do you use nutritional supplements? Yes No If yes, what type? _____

How old is your mattress? _____ Is it comfortable? _____

Pain Drawing:

- Mark the areas of your body where you feel pain. Include all affected areas.
- If your pain radiates, draw an arrow from where it starts to where it stops.
- Extend the arrow as far as the pain travels.
- Use the appropriate symbol(s) below.

ACHE >>>>>

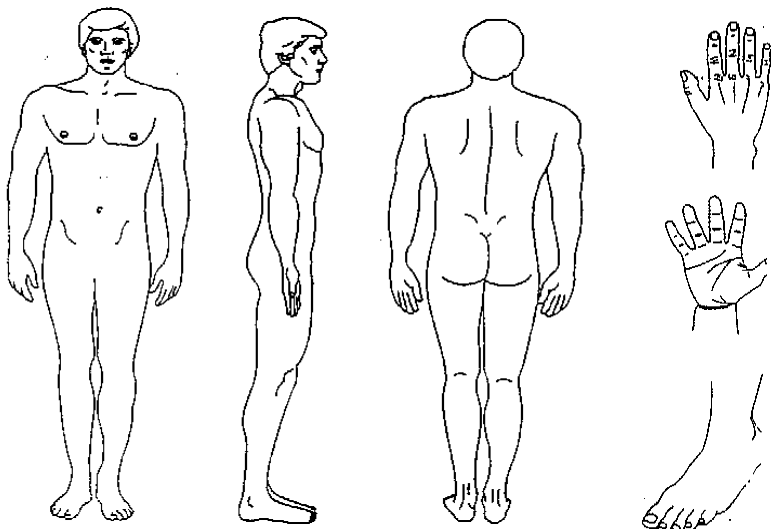
BURNING XXXXXX

NUMBNESS =====

PINS & NEEDLES 000000

STABBING /////

THROBBING -----



Chiropractic Health Questionnaire

Name: _____

Date: _____

Have you been treated before for this problem? Yes No

Have you ever had chiropractic care previously? Yes No

If Yes, when and what type of treatment was rendered? _____

Was the treatment helpful? Yes No

Date of last comprehensive physical exam? _____

Female : Date of last female specific exam or OB/GYN exam? _____*Male*: Date of last male specific exam or prostate exam? _____

Check all examinations below that have shown any abnormal findings:

- ☐ Bone Scan
- ☐ CT Scan
- ☐ MRI
- ☐ X-Ray
- ☐ Mammogram
- ☐ Upper GI
- ☐ Lower GI
- ☐ Nerve Conduction Study
- ☐ Urinary test
- ☐ DEXA or Bone Scan
- ☐ Blood test

Sleep hours per night: _____

Do you awake rested? Yes No

Is your pillow comfortable? Yes No

Do you use a heel lift? Yes No

Do you use orthotics? Yes No

Are they comfortable? Yes No

Surgeries: _____

*Check all that apply:***GASTROINTESTINAL**

- ☐ Acid reflux
- ☐ Anemia
- ☐ Bloating
- ☐ Bowel changes
- ☐ Change in weight
- ☐ Chew Tobacco
- ☐ Colitis
- ☐ Constipation
- ☐ Difficulty swallowing
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gallbladder pain
- ☐ Hemorrhoids
- ☐ High alcohol intake
- ☐ Indigestion
- ☐ Intestinal gas
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Ulcers
- ☐ Vomiting

METABOLIC

- ☐ Allergies
- ☐ Cancer
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Hepatitis
- ☐ Kidney stones
- ☐ Osteoporosis
- ☐ Thyroid problems

NEUROMUSCULOSKELETAL

- ☐ Arthritis
- ☐ Blurred vision
- ☐ Bone disease
- ☐ Carpal tunnel syndrome
- ☐ Cataracts
- ☐ Degenerative joint disease
- ☐ Depression
- ☐ Fatigue/Exhaustion
- ☐ Forgetfulness
- ☐ Fractures
- ☐ Glaucoma
- ☐ Headache
- ☐ Hearing loss
- ☐ Infection
- ☐ Liver disease
- ☐ Migraine headaches
- ☐ Multiple sclerosis
- ☐ Psoriasis
- ☐ Rheumatoid arthritis
- ☐ Ringing in ears
- ☐ Seizures
- ☐ Sleep loss
- ☐ Sweats
- ☐ Tiredness
- ☐ TMJ pain

CARDIOVASCULAR

- ☐ Asthma
- ☐ Bleeding gums
- ☐ Bruise easily
- ☐ Chest pain
- ☐ Difficulty breathing
- ☐ Dizziness
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol

CARDIOVASCULAR cont'd

- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Poor circulation
- ☐ Rheumatic fever
- ☐ Smoke Tobacco
- ☐ Stroke
- ☐ Swelling of ankles/legs
- ☐ Tuberculosis
- ☐ Varicose veins

❖ **FEMALE GENITOURINARY**

- ☐ Abnormal pap smear
- ☐ Bladder control problems
- ☐ Bladder infections
- ☐ Bleeding between periods
- ☐ Blood in urine
- ☐ Breast lump
- ☐ Endometriosis
- ☐ Frequent urination
- ☐ Hernia
- ☐ Hot flashes
- ☐ Infertility
- ☐ Premenstrual syndrome
- ☐ Currently Pregnant

❖ **MALE GENITOURINARY**

- ☐ Bladder control problems
- ☐ Blood in urine
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Frequent urination
- ☐ Hernia
- ☐ Infertility
- ☐ Prostate hypertrophy