ChiroHealth

ChiroHealth of Rockford
6769 Courtland Drive
Suite 100
Rockford, Michigan 49341
(616) 863-9482 Office
(616) 863-9486 Facsimile

Patient Intake Form

Welcome to the office of ChiroHealth. Please fill out this **Patient Intake Form** completely and to the best of your knowledge. Let our staff know if you have any questions. When complete, return this **Intake Form** along with the **Office Policy** and **HIPPA Form** with appropriate signatures and initials filled in.

Patient Information

Personal Information

*First Name: _____
Middle Name: _____
*Last Name: _____
*Gender: ___Female ___Male
*Date of Birth: _____
Social Security #: _____
Height: _____Feet _____Inches
Weight: _____lbs.
Marital Status: _Single _Married _Other
Spouse's Name: _____
Number of Children: _____

Emergency Contact: _____
Relationship: _____
Phone: _____

Contact Information

*Email: _____
(We will NOT share your email with any third party. We will only use your email to contact you in relation to your care with our practice)

*Home Phone: _____
*Cell Phone: _____
Work Phone: _____

* Address Line 1: _____
Address Line 2: _____
*City: _____
* State: _____
*Zip/Postal Code: _____

How did you hear about our office? ____Friend/Family
Name: _____
____Internet ____Community Event
____Insurance List ____Drive By ____Other

Employment Information

Regular Work Status: _ Full Time _ Part Time _ Unemployed _ Retired _ Student
Employer Name: _____
Employer Address: _____
Employer City: _____
Employer State: _____ Employer Zip: _____
Occupation: _____

Insurance & Payment for Care

How do you plan to pay for care? ____ Personal Insurance ___ Third-Party Insurance _____ No Insurance, Self-Pay

Name of Person(s) Responsible for Payment: _____

Responsible Party Phone: _____

Primary Insurance

Insurance Name: _____

Phone: _____

Address: _____

City: _____

State: _____ Zip: _____

ID/Policy #: _____

Group #: _____

Insured's Name: _____

Insured's Date of Birth: _____

Secondary Insurance

Insurance Name: _____

Phone: _____

Address: _____

City: _____

State: _____Zip: _____

ID/Policy #: _____

Group #: _____

Insured's Name: _____

Insured's Date of Birth: _____

Authorization/Consent to Treat

I certify that I am the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

* ____ **I agree with this statement of authorization**

Name of the Patient: _____

(please print)

Signature of Patient, Parent or Legal Guardian (if a minor):

_____

Date: _____

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Health Questionnaire

Patient Name: _____ **DOB:** _____ **Today's Date:** _____

What is the purpose of your visit today? ___Wellness ___Complaint ___Injury ___Other

What type of complaint do you have? ___Acute ___Chronic ___Recurring ___Sub-Acute ___No Musculoskeletal Complaints

Where is your Chief Complaint? _____
(this is your primary area of pain/discomfort only, additional complaints are below)

How did this injury, pain or discomfort originate? _____

When did this condition begin? (use date if known) _____

Was this condition caused by a FALL, INJURY or ACCIDENT? ___No ___Yes: (explain) _____

What is the frequency of your pain? ___Constant ___Frequent ___Occasional ___Intermittent

What is the quality of discomfort? ___Aching ___Annoying ___Burning ___Deep ___Diffuse ___Dull ___Heavy ___Intolerable ___Pulling ___Sharp ___"Shock Like" ___Stabbing ___"Stiffness" ___Throbbing ___"Tightness" ___Tingling ___Other

If the discomfort radiates, where does it travel to? _____

Is this complaint getting better, worse, or staying the same? ___Improved ___Worsened ___Relief that lasted awhile ___Same

What would you rate your pain? (0-10 with 10 being extreme) _____

What are your symptoms relieved by? ___Nothing ___Cold Packs ___Exercise ___Heat Packs ___Massage ___Chiropractic ___Over the Counter Meds ___Physical Therapy ___Prescription Meds ___Rest ___Stretching ___Work ___Other

What aggravates the symptoms? ___Nothing ___Almost any movement ___Bending ___Carrying ___Changing positions ___Climbing Stairs ___Coughing/Sneezing ___Driving ___Sleeping ___Getting out of car ___Getting out of bed ___Getting up from laying ___Getting up from sitting ___Household chores ___Lifting ___Looking over shoulder ___Pulling ___Pushing ___Reaching ___Running ___Sitting ___Squatting ___Standing ___Stretching ___Turning ___Twisting ___Walking ___Working ___Yard Work ___Other

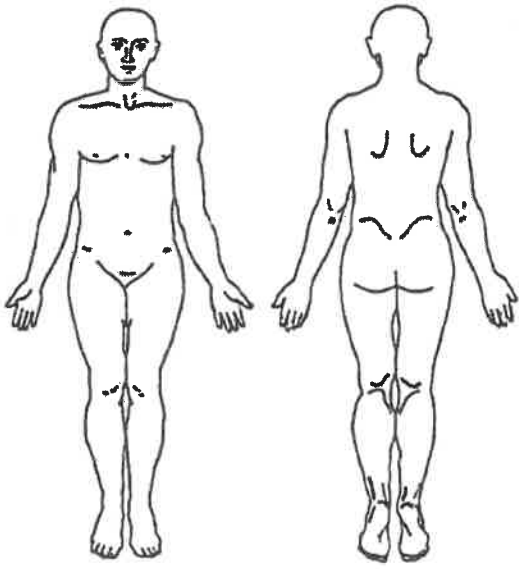
Have you had any past episodes of this complaint? ___No
___Yes: (explain) _____

Have you received any past care for this current complaint? ___No
___Yes: (explain) _____

Any diagnostic images or tests for this complaint? ___No ___Yes

Do you have any additional complaints? ___No ___Yes

*Please mark your areas of pain



Complaint #2

Acute, chronic, or recurring? _____

Where is this complaint located? _____

Rate your pain ? (0-10) _____

Complaint #3

Acute, chronic or recurring? _____

Where is the complaint located? _____

Rate your pain? (0-10) _____

Personal Health History

Name of Primary/Family Physician: _____

Address: _____

Phone: _____

Date of last physical exam: _____

Please check ALL of the health conditions below that apply to you currently or in the past.

___Osteoarthritis _Whiplash __Headaches __Migraines __Rheumatoid Arthritis __Disc Herniation __Joint Pain

___Osteoporosis _Fibromyalgia _Asthma __Diabetes _Anemia __Cancer/Tumor _Depression/Anxiety

___High Blood Pressure ____Heart Disease/Stroke __Epilepsy/Seizures _Genetic Disorders ____Infertility __Constipation

Please list any other medical conditions: _____

Please check ALL conditions that run in your family. (father, mother, sister, brother)

___Cancer __Anemia __Diabetes __Heart Problems/Stroke __High Blood Pressure ___Genetic Disorders __Arthritis

Please list any other medical conditions: _____

WOMEN ONLY: Currently Pregnant? No_Yes **Painful/Abnormal/Absent Menstrual Cycle?** No_Yes

Menopause? _ No _Yes **Do you have children?** _ No _Yes: Vaginal or C-Section

First Day of Last Menstrual Cycle: _____

Fractures (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date):

_____

_____

Surgeries and/or Hospitalizations (List and Date):

_____

_____

List of current prescription medications, over the counter medications, and supplements. (Including frequency and dosage if known)

1. _____ **2.** _____

3. _____ **4.** _____

5. _____ **6.** _____

* You may provide us with a photocopy of your medications

Social History:

Do you exercise? ____No ___Yes **Times per week?** ___ **Intensity?** __Light __Moderate __Strenuous

Do you currently smoke tobacco of any kind? ___No ___Yes **How often?** ___Everyday __Intermittent

Do you drink alcohol? _No _Yes **How many drinks per week?** _

Do you drink caffeine? _No _Yes **How many drinks per day?** _

Do you take pain killers? _No _Yes **How often?** _Daily __Weekly __Monthly __Rarely

Describe your overall health right now? Excellent _Very Good _Good __Fair ___Poor

What is your current stress level? Mild __Moderate _High

Have you seen a chiropractor in the past? ___No ___Yes **Date of last chiropractic adjustment:** _____

What are your specific therapeutic goals? ____Sleep thru the night ____Decrease swelling ____Improve range of motion ____Lift

___Improve strength ____Improve flexibility ___Decrease stiffness ___Relieve pain ____Walk without limitation ____Return to sports

___Work without limitations ____Other: (explain) _____

ChiroHealth HIPAA Form

Patient's Name: _____

Patient's SSN: _____ Date of Birth: _____

SPECIFIC AUTHORIZATIONS-CHECK ALL THAT APPLY

( ) I give permission to **ChiroHealth Rockford** to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, and any information about treatment(s). If **ChiroHealth Rockford** contacts me by phone; I give them permission to leave a phone message on my answering machine or voicemail.

( ) I give **ChiroHealth Rockford** permission to use and disclose my protected health information to the entities of my choosing, some of which may or may not be listed below.

APPROVED ENTITIES FOR PERSONAL HEALTH INFORMATION

Name: _____ Relationship: _____

Approved type(s) of information: ( ) Diagnosis ( ) Treatments ( ) Appointments ( ) Financial Records

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Name: _____ Relationship: _____

Approved type(s) of information: ( ) Diagnosis ( ) Treatments ( ) Appointments ( ) Financial Records

_____

Signature of Patient or Personal Representative

( ) I understand that if applicable your substance use disorder (SUD) records, or testimony relaying the content of those records, may not be used or disclosed in any civil, criminal, administrative, or legislative proceedings against you without your written consent or a court order that meets specific legal requirements. Any such court order must be accompanied by a subpoena or other legal mandate before we are required to disclose the record.

( ) I am aware that once we share your information with an authorized recipient (such as your insurance company or another doctor), that recipient may further share that information as permitted by law. Once redisclosed, the information may no longer be protected by the same federal privacy rules (42 CFR Part 2) that apply to our program.

Date: _____

RIGHT TO REVOKE HIPAA AUTHORIZATION

- You have the right to revoke this authorization, in writing, at any time. Please send such requests to:
  ChiroHealth Rockford
  Attn: Office Manager
  6769 Courtland Dr. Ste. 100
  Rockford, MI 49341
  Phone: 616-863-9482
  Fax: 616-863-9486

  Initials: _____

- You may refuse to sign this HIPAA authorization. If you refuse to sign this authorization it will not affect your ability to obtain treatments.

- Upon request, a copy of this authorization will be provided to you.

- Upon request, a copy of the Health Insurance Portability and Accountability Act will be provided to you.

- If you believe your privacy rights regarding substance use disorder records have been violated, you may file a complaint with us or with the Secretary of Health and Human Services through the Office for Civil Rights (OCR). You will not be retaliated against for filing a complaint.

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OFFICE POLICIES

NO SHOW/CANCELLATION POLICY

We understand that life and emergencies happen, but we do ask that if you cannot keep your appointment, please call us within 24 hours to cancel and reschedule your appointment. You can leave a message on our answering machine and one of our team members will gladly reschedule your appointment for you. If you do not show up for your appointment, and did not call ahead to Cancel (NO-CALL/NO-SHOW), you will be charged a $25 NO-CALL/NO-SHOW Missed appointment fee for chiropractic.

***PLEASE READ BELOW FOR ALL CHARGES.....**

No-Show Policy-Chiropractic Adjustment Appointments $25

A No-Show appointment fee of $25 will be charged to you for any missed Chiropractic appointments.

24 Hr cancellation & No-Show Policy-Scheduled Massage Therapy Appointments $50

A No-Show appointment fee of $50 will be charged to you for any missed Massage appointments.

Less than 24hr notice a late cancellation fee of $50 will be charged to you for any missed Massage appointments.

***Our office allows you 5 minutes before and after your massage to talk to your therapist, undress/redress, and get yourself on/off the table. This means a 30 minute massage is 20 minute hands on therapy. A 60 minute massage is a 50 minute hands on therapy. A 90 minute massage is an 80 minute hands on therapy. A 120 minute massage is a 110 minute hands on therapy. This allows your therapist to customize your session as they deem appropriate. Please note it also helps keep our scheduled appointments to run on time.*

FINANCIAL POLICY

Payment is due at the time of service. The amount due for services will depend on whether you have insurance, are self-pay, or are going through a Third Party Administrator. See below for further information regarding insurance, self-pay and Third Party Administrator. The accompanying adult to a minor patient is responsible for payment. For your convenience, we accept credit card, cash, and checks.

***Insurance:** Our services are rendered to you, not your insurance company. In most cases we will call to verify your insurance benefits. However, the benefits quoted to us by your insurance company are not a guarantee of payment. We will bill your insurance plan and collect any copy, co- insurance, or deductible due by you at the time of service. Any non-covered service fees will also be collected at the time of service. If your health plan determines a service to be "**not covered**" or is **not an eligible expense under your plan**, you will be responsible for the complete charge or remaining balance of the non-covered service(s). Payment is due upon receipt of the explanation of benefits from your insurance company. It is uncommon, but pre-authorization from your insurance company or PCP may be required for your plan. Please contact our office or your insurance company to verify your plan benefits. If required, an authorization may be able to be processed by our office or you may need the authorization from your PCP.

***Self Pay (No Insurance):** Full payment is due at the time of service.

Personal Injury/Auto Injury/Worker's Comp (Third Party Administrators): Please advise our office on your first visit whenever you have one of these listed claims. We will work with any insurance company(s)/attorneys involved, but please remember that you are ultimately responsible for your bill if payment cannot be obtained from another party within a reasonable time. If you, your attorney or the insurance company does not cooperate in protecting the doctor's interest, we will not await payment and may declare the entire balance due and payable immediately.

Special Arrangement: We have never denied anyone the benefits of chiropractic care because of their inability to pay our published fees. If financial hardship exists, it requires an Individual Consideration Contract. Please speak with the front desk staff.

Balance: Failure to pay any balance due may result in your account being turned over to an outside collection agency.
Any balance that is 60 days passed the processed insurance date will be charged an additional $5.00 late fee. For any additional 30 days after that date another $5.00 late fee will be added.

* ChiroHealth offers a time of service discount of 10% for Self Pay patients as well as for services that are a non-covered benefit when we bill Insurance. This discount does not apply to nutritional supplements, customized orthotics or supplies. For additional discounts, please ask one of our team members about CHIROHEALTH USA, which can help you save even more for Self Pay patients and non-covered services for Insurance patients.

I have read and understand the financial policy set forth by ChiroHealth, and I agree to be bound by its terms. I understand that my insurance is an arrangement between myself and my insurance company. I request ChiroHealth prepare customary forms at no charge so I may obtain insurance benefits. I understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care prescribed to me by the doctors of ChiroHealth, fees will be due and payable immediately. I understand and agree that such terms may be amended periodically by the practice.

Patient Name: _____
Please print

Financially Responsible Party: _____
Please print

Patient/Financially Responsible Party: _____ Date: _____