Welcome

Smithfield Chiropractic

Patient Information

Patient Name: _____ **Date:** _____

Address: _____

_____

City, State, and Zip

Date of Birth: _____ **Gender:** □ Male □ Female

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

Patient SS#: _____ **Email Address:** _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated

Ethnicity: □ Hispanic/Latino □ Not Hispanic/ Latino

Race: □ White □ American Indian/Alaskan Native □ Asian □ Black/ African American □ Pacific Isl.

Language: □ English □ Spanish □ Other: _____

Smoking Status: □ Everyday □ Some days □ Former smoker □ Never Smoked

Insurance/Patient Responsibility/Self pay

Primary Insurance: _____ Secondary Insurance: _____

Policy #_____ Policy #_____

Policy Holder's Name_____ Policy Holders Name_____

Emergency Contact

Name: _____ Relationship: _____

Home phone: _____ Work or Cell Phone: _____

Whom may we thank for referring you?:_____

PATIENT FINANCIAL ACKNOWLEDGEMENT

Please read thoroughly. Initial your acknowledgement, then sign and print your name and date. Thankyou.

ASSIGNMENT OF BENEFITS

☐ I assign all benefits payable to me for my care at Smithfield Chiropractic. I understand that this health care facility will be paid directly by the insurance company or other payer. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as theoriginal.

GUARANTEE OF PAYMENT

☐ I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility. I understand that I am financially responsible for all charges independent of insurance payments. I clearly understand and agree that all services made to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will be immediately due and payable. Should your account be turned over for collection, the undersigned agrees to pay all costs to collect the debt including, but not limited to, interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third-party debt collection agency.

SIGNATURE (PATIENT | GUARDIAN) _____ PRINT NAME _____ DATE _____

Office Use Only

United Health Care	ASHN plans	Bind	BCBS	Medicare	Medical	Select Care	PIP	Other

☐ CHIROPRACTIC

1. Deductible/co-insurance? _____
2. Is there a co-pay? $_____
3. Limit on visits or services? _____

- ☐ 992XX (Examination)
- ☐ 97110 (Therapeutic exercise)
- ☐ 97112 (NMS re-education)

- ☐ EXTRA SPINAL MANIPULATION
- ☐ LABORATORY
- ☐ Orthotics_____# per year
- ☐ Orthotics NOT verified

- ☐ Other:

_____
_____
_____
_____
☐ _____

☐ ACUPUNCTURE

1. Deductible/co-insurance? _____
2. Co-pay? $_____
3. Limit on visits or services? _____
4. Authorization/Precertification needed? ____

98913 (Acupuncture w/ Stim)

☐ ACUPUNCTURE BENEFITS NOT VERIFIED

☐ ACUPUNCTURE NOT A BENEFIT ON THIS PLAN

☐ MASSAGE THERAPY

1. Deductible/co-insurance? _____
2. Co-pay? $_____

- ☐ 97124 Massage Therapy)
- ☐ 97140 (Myofasical Release)

☐ MASSAGE BENEFITS NOT VERIFIED

☐ MASSAGE NOT A BENEFIT ON THIS PLAN

BASED ON THE INFORMATION PROVIDED BY THE HEALTH INSURANCE PLAN, SERVICES CHECKED ABOVE ARE NOT COVERED.

Important insurance information please read

Your insurance company requires that we bill and collect from you the amount that it determines to be patient responsibility. At this point we do not know what amount your insurance company will determine to be patient responsibility. This amount is determined by numerous factors, including whether or not you have met your annual deductible, whether your out of pocket maximum has been met, and the amount of "coinsurance" you are required to pay for covered services under your health plan. We are determined to help you meet this responsibility required by your insurance company. After your insurance company pays its portion of the claim, we will bill you for the amount your health insurance company determines to be patient responsibility.

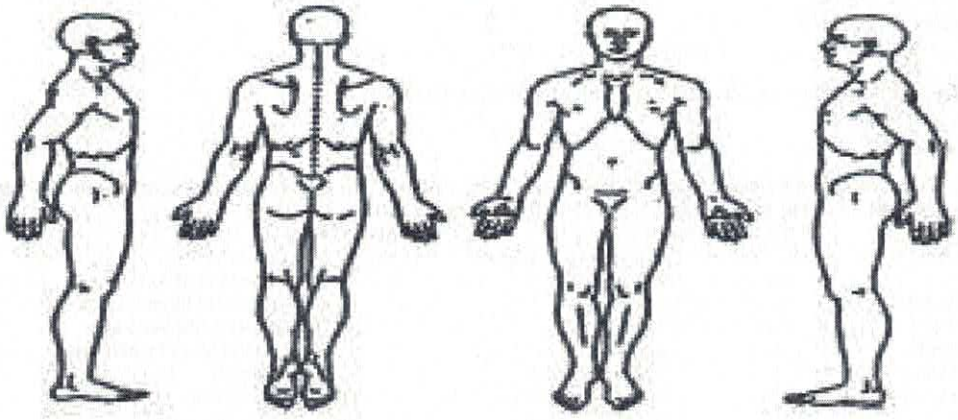
Patient Signature: _____ Date:_____

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time)
□ Frequently (51-75% of the time)
□ Occasionally (26-50% of the time)
□ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp
□ Dull
□ Diffuse
□ Achy
□ Burning
□ Shooting
□ Stiff
□ Numb
□ Tingly
□ Sharp with motion
□ Shooting with motion
□ Stabbing with motion
□ Electric like with motion
□ Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor
□ ER physician
□ Massage Therapist
□ Neurologist
□ Orthopedist
□ Physical Therapist
□ Primary Care Physician
□ Other:_____
□ No one

10. How long have you had this problem? _____ months years days

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What aggravates your problem?

_____

14. What alleviates your problem?

_____

15. What concerns you the most about your problem; what does it prevent you from doing?

_____

16. What is your: **Height**_____ **Weight** _____ **Date of Birth** _____
Occupation _____

17. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

18. What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ None

19. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

20. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:_____				

21. List all prescription medications you are currently taking:
_____

22. List any prescription allergies:
_____

23. List all of the over-the-counter medications/supplements you are currently taking:
_____

24. List all surgical procedures you have had:
_____

25. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

26. What activities do you do outside of work?
_____

27. Have you ever been hospitalized? □ No □ Yes
If yes, why _____

28. Have you previously seen a chiropractor for this problem? How long ago?
_____

29. Anything else pertinent to your visit today?_____

Patient Signature_____ **Date:**_____

CHIROPRACTIC INFORMED CONSENT

I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic treatment or management of my condition(s).

Chiropractic treatment or management of conditions almost always includes the chiropractic adjustment, a specific type of joint manipulation. Like most health care procedures, the chiropractic adjustment carries with it some risks. Unlike many such procedures, the serious risks associated with the chiropractic adjustment are extremely rare.

Following are the known risks:

Temporary soreness or increased symptoms or pain It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments.

Dizziness, nausea, flushing These symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care.

Fractures When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture.

Disc herniation or prolapse Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.

Stroke A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before or during their stroke.

Other risks associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat.

Bruising Instrument assisted soft tissue manipulation may result in temporary soreness or bruising.

I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care.

• PATIENT PLEASE REVIEW • PRINT & SIGN NAME •

I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely.

PATIENT'S NAME (Print)_____ DATE OF BIRTH_____

_____ _____ _____ _____

(PATIENT | GUARDIAN SIGNATURE) (DATE) (TRANSLATOR | INTERPRETER SIGNATURE) (if applicable) (DATE)

CLINICIAN ONLY

Based on my personal observation and the patient's history, I conclude that throughout the informed consent process the patient was:

☐ OF LEGAL AGE ☐ APPEARS UNIMPAIRED ☐ CONSENT GIVEN THROUGH GUARDIAN

☐ ORIENTED X3 ☐ FLUENT IN ENGLISH ☐ ASSISTED BY A TRANSLATOR OR INTERPRETER

_____, D.C. _____

(D.C. SIGNATURE) (DATE)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

Smithfield Chiropractic is committed to patient privacy and the confidentiality of personal health information entrusted to us.

The ways in which we may use or disclose your health information are detailed in the Notice of Privacy Practices.

Your Right to Limit Uses or Disclosures: You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, we will provide you with a Limitation of Use and Disclosure of Protected Health Information Request form.

Your Right to Request that Your Patient Record be Amended: You have the right to request that we amend the information in your patient record. If you would like to amend any information in your record we will provide you with a Request to Amend Protected Health Information form.

Your Right to Revoke Your Authorization: You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

YOU HAVE A RIGHT TO REFUSE CONSENT FOR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION. WITHOUT YOUR CONSENT, HOWEVER, SMITHFIELD CHIROPRACTIC WILL NOT BE ABLE TO SUBMIT CLAIMS TO INSURANCE CARRIERS OR OTHER THIRD PARTY PAYERS AND MAY NOT ACCEPT YOU AS A PATIENT/CLIENT.

Initial here [ ] ***I acknowledge receipt of the Smithfield Chiropractic - Notice of Privacy Practices***

By signing below, I give consent to the Smithfield Chiropractic-clinicians or staff to use or disclose my personal health information as noted in the Notice of Privacy Practices.

_____ _____

Printed Name **Authorized Provider Representative**

_____ _____

Signature **Date**

_____

Date