CHIRO CARE®
ASSOCIATES

INTAKE FORM – PAGE 1/2

TODAY'S DATE: ____________________

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MI:	❑ MR. ❑ MS. ❑ DR.	❑ MRS. ❑ MISS.	MARITAL STATUS (*PLEASE CHECK*) ❑ S ❑ M ❑ D ❑ W

SOCIAL SECURITY #: (*LAST **4** DIGITS ONLY*)	HOME PHONE #: ( )	CELL PHONE #: ( )	BIRTH DATE: / /	AGE:	GENDER:

STREET ADDRESS:	CITY:	STATE:	ZIP CODE:	EMAIL ADDRESS:

OCCUPATION:	EMPLOYER NAME:	WORK PHONE #: ( ) EXT.

EMPLOYER STREET ADDRESS:	CITY:	STATE:	ZIP CODE:

NAME OF YOUR PRIMARY CARE PHYSICIAN:	ADDRESS:	OFFICE PHONE #: ( )

WHO MAY WE THANK FOR REFERRING YOU TO CHIROCARE? ❑ DR. ______________________________ ❑ INSURANCE PLAN ❑ FAMILY MEMBER

❑ FRIEND ❑ CLOSE TO HOME / WORK ❑ YELLOW PAGES ❑ ONLINE OTHER:

HEALTH INSURANCE INFORMATION – PRIMARY

ARE YOU COVERED BY HEALTH INSURANCE?	❑ YES ❑ NO	NAME OF INSURANCE COMPANY:

SUBSCRIBER'S NAME: ❑ *SAME AS ABOVE*	BIRTH DATE: / /	POLICY #:	GROUP #:

SUBSCRIBER'S ADDRESS: ❑ *SAME AS ABOVE*	ADDRESS:	CITY:	STATE:	ZIP CODE:

RELATIONSHIP TO SUBSCRIBER: ❑ SELF ❑ SPOUSE ❑ CHILD ❑ DOMESTIC PARTNER ❑ OTHER:

HEALTH INSURANCE INFORMATION – SECONDARY (*IF APPLICABLE*)

ARE YOU COVERED BY ANY SECONDARY HEALTH INSURANCE?	❑ YES ❑ NO	NAME OF INSURANCE COMPANY:

SUBSCRIBER'S NAME: ❑ SAME AS ABOVE	BIRTH DATE: / /	POLICY #:	GROUP #:

SUBSCRIBER'S ADDRESS: ❑ SAME AS ABOVE	ADDRESS:	CITY:	STATE:	ZIP CODE:

RELATIONSHIP TO SUBSCRIBER: ❑ SELF ❑ SPOUSE ❑ CHILD ❑ DOMESTIC PARTNER ❑ OTHER:

IN CASE OF EMERGENCY

NAME OF LOCAL FRIEND OR RELATIVE :	RELATIONSHIP TO PATIENT:	❑ HOME *OR* ❑ CELL PHONE #: ( )	WORK PHONE #: ( )

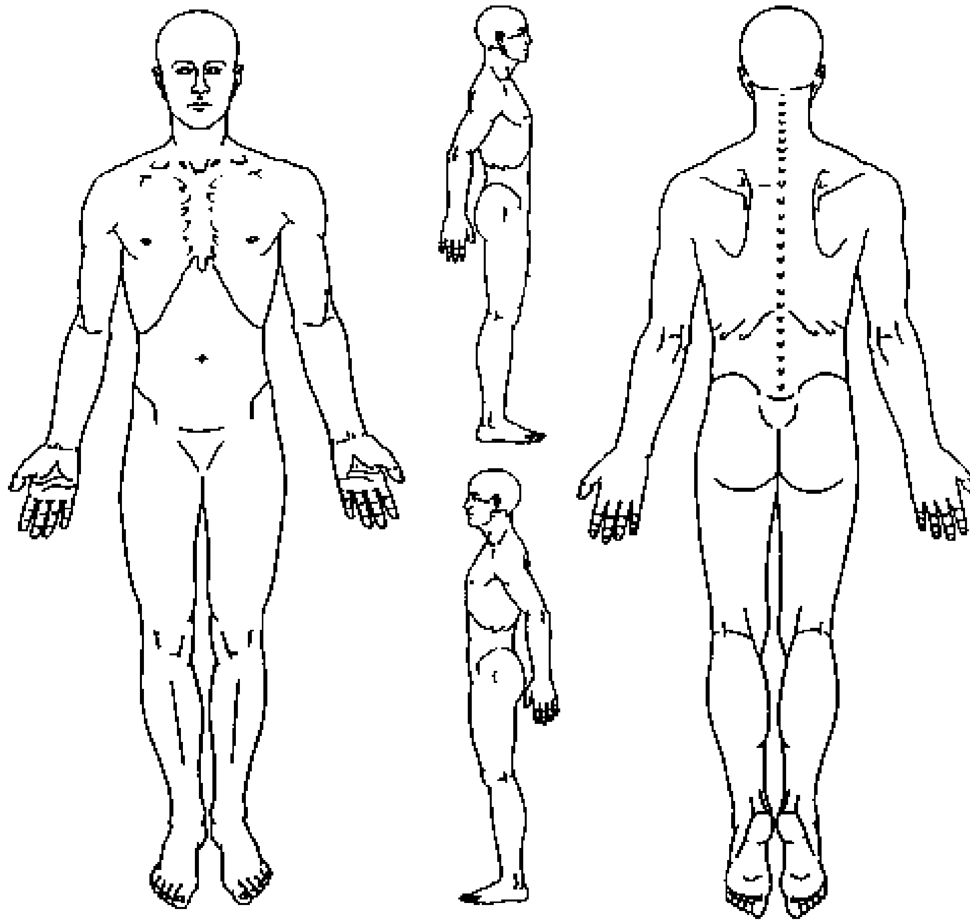
THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I ASSIGN DIRECTLY TO **CHIROCARE ASSOCIATES, PC** ALL MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE CHIROCARE ASSOCIATES, PC TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THHIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS.

____ ____________________

SIGNATURE OF PATIENT / LEGAL REPRESENTATIVE: ***DATE:***

– TURN OVER –

PATIENT INFORMATION			
LAST NAME:	FIRST NAME:	MI:	DATE:



PLEASE MARK WHERE YOU ARE FEELING PAIN.

X = ache	✓= stabbing	△ = burning	○ = pins and needles/numbness	□ = other

PLEASE CIRCLE YOUR CURRENT PAIN LEVEL: 0 = NO PAIN 10 = WORST PAIN.											
NECK PAIN:	0	1	2	3	4	5	6	7	8	9	10
MID BACK PAIN:	0	1	2	3	4	5	6	7	8	9	10
LOW BACK PAIN:	0	1	2	3	4	5	6	7	8	9	10
OTHER:	0	1	2	3	4	5	6	7	8	9	10
OTHER:	0	1	2	3	4	5	6	7	8	9	10

PLEASE CIRCLE HOW OFTEN YOU HAVE YOUR PAIN.				
NECK PAIN:	0 - 25%	26 - 50%	51 - 75%	76 - 100%
MID BACK PAIN:	0 - 25%	26 - 50%	51 - 75%	76 - 100%
LOW BACK PAIN:	0 - 25%	26 - 50%	51 - 75%	76 - 100%
OTHER:	0 - 25%	26 - 50%	51 - 75%	76 - 100%
OTHER:	0 - 25%	26 - 50%	51 - 75%	76 - 100%

CHIRO CARE ASSOCIATES

FINANCIAL POLICY

Restoring your health is our foremost objective. Our treatment will always be rendered solely on the basis of need. Please advise us if you are unable to fulfill this policy so that we may discuss and consider alternative payment options. We require payment at the time of service unless special arrangement has been previously made. Our fees comply with the “usual and customary” rated for this region. We accept cash, checks, and some credit cards. For patients who are unable to pay at the time of service, special arrangements may be available upon request.

REGARDING ALL INSURANCE: We cannot promise that an insurance company will pay for your care, even when it is preauthorized. We will submit bills to your insurance carrier but will not become involved in disputes between the insured and the insurance company. This courtesy will commence as soon as we are able to confirm coverage for chiropractic services and have the proper, signed insurance forms. Payment of non-covered ad services balances, co-payment and deductibles is expected at the time of service. We strongly urge you to contact your insurance company to verify your benefits; sometime incorrect information is provided to us.

If an insurance company fails to pay for services within ninety days, the undersigned is responsible for payment. Ultimately, you are responsible for all outstanding balances. If the insurance company erroneously pays directly to the insured, the amount shall be forwarded to this office within three business days.

MEDICARE: Medicare pays only for a portion of chiropractic services and limits the number of reimbursable treatments. Reimbursable care is limited to spinal manipulation and does not include therapies, services and goods that may be necessary during care. Please be advised of the following Medicare restrictions and regulations.

- Medicare will pay for a maximum number of treatments per calendar year, based on your diagnosis. When the maximum number of treatments has been rendered; payment is expected at the time of service.
- Medicare will not pay for an initial examination. This fee is the patient’s responsibility and will not apply to the patient’s deducible.

PERSONAL INJURY, WORKER’S COMPENSATION AND/OR LITIGATION: If your complaint is the result of an occupational or automobile accident, or if litigation is pending, please notify us. If an attorney is involved, patients are required to sign a Physician’s Lien that will be forwarded to the attorney for signature. If we do not receive the signed lien from the attorney within fourteen days, all services must be paid for by the patient at the time rendered. It is our policy to bill the insurance company directly and will provide the attorney with monthly statement.

Instances will arise when we exhaust all reasonable efforts to secure payment from your insurance company, but the insurance company refuses payment. We will our best to assist you in securing payment, but all balances are ultimately your responsibility.

MISSED APPOINTMENT: There is a **$50.00** charge for missed appointments without a 24-hour notice. This charge is the patient’s responsibility and cannot be billed to the insurance company. Missed appointment fees must be paid before scheduling subsequent appointment. We may request a deposit for future appointments. If more than 3 appointments are missed without notification, we may recommend that you seek treatment at another facility, or schedule when you are more able to adhere to the recommended treatment plan. **Initial Here** ____________

In fairness to our patients who do pay for services, after reasonable efforts on our part to obtain payment, we will solicit the services of a collection agency if necessary.

I have read this policy and understand that I am financially responsible for all unpaid balance for my care

Patient Name ________________________________

Sign Here ________________________________ **Date Here** ______________

☐ SELF ☐ PARENT / LEGAL REPRESENTATIVE

Reviewed By ________________________________ **Date Here** ______________

My Initials, below, certifies that I have been offered and/or have received a copy of ChiroCare Associates, PC Notice of Privacy Practice

Initial Here ____________

CHIRO CARE® ASSOCIATES

INFORMED CONSENT

THE NATURE OF THE CHIROPRACTIC ADJUSTMENT

The primary treatment that a Doctor of Chiropractic uses is spinal manipulative therapy. We may use our hands or a mechanical instrument in such a way as to improve your joint motion. This may cause an audible "pop" much as you may have experienced when you "crack" your knuckles. You may also feel a sense of movement during the adjustment.

RECOMMENDED TREATMENT PROCEDURES

As a part of the chiropractic treatment you will be consenting to the following procedures which may be included as part of your treatment:

- Manipulative Therapy
- Webster Technique
- Neuromuscular Re-education
- Myofascial Release
- Manual Therapy Techniques
- Manual Adhesion Release®
- Joint Mobilization
- Graston Technique®
- Electric Muscle Stimulation
- Therapeutic Exercise
- Vasopneumatic Percussion
- Instrument Adhesion Release®
- McKenzie Method®
- Hot / Cold Therapy
- Ultrasound
- Kinesio Taping®
- Manual Traction
- Integrative Diagnosis®

THE MATERIAL RISKS AND PROBABILITY INHERENT IN CHIROPRACTIC MANIPULATION THERAPY AND TREATMENT

As with many healthcare procedures, there are certain complications which may arise during chiropractic treatment. These complications include but are not limited to fractures, disc injuries, dislocations, muscle strains, cervical/lumbar myelopathy, costovertebral strains, and burns. Some types of manipulation to the neck have been associated with arterial injury which may contribute to serious complications including stroke. These occurrences are generally rare, and stroke associated with manipulation has been the subject of great disagreement. Current research indicates that this incidence is approximately 1 in 1 million to 1 in 5 million cervical adjustments. The most common symptom you may experience is stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for such contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

THE AVAILABILITY AND NATURE OF OTHER TREATMENT OPTIONS

Other treatment options for your condition may include but are not limited to:

- self-administered OTC analgesics and rest
- medical care and prescription medication (i.e. NSAID's)
- referral to additional healthcare providers (i.e. Physical Therapy)

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I certify that I have read the above explanations regarding chiropractic treatment, discussed it with the Doctor of Chiropractic and have had any questions answered to my satisfaction. By signing below and having been informed of the material risks, I have given my consent to initiate chiropractic treatment.

Patient Name ________________________________

Sign Here ________________________________ ***Date Here*** ______________

☐ ***SELF*** ☐ *PARENT / LEGAL REPRESENTATIVE*