Back Together Again Chiropractic

A) PATIENT INTAKE/TREATMENT FORM

1) Patient Name: _____2) e-mail: _____

3) Home Phone number: (___)_____ ___, Cell: (___)_____, Work:(___)_____

4) Address: _____
City, State, Zip Code

5) Gender M F 6) Date of Birth (DOB): ____/____/____

7) Marital Status: S: ___ M: ___ Other: ___

8) Emergency contact: _____Relation: _____Emergency #:_____

9) How did you hear about us? (please circle) Doctor Family Friend TV Ad Print Ad Website Other: _____

PATIENT MEDICAL HISTORY

PLEASE MARK THE FOLLOWING IF YOU HAVE HAD:

____ Angina
____ Heart Attacks
____ Stroke
____ Heart Surgery
____ Tumors
____ Diabetes
____ Epilepsy
____ Arthritis
____ Circulatory Problems
____ Osteoporosis
____ Emotional Problems
____ Nervous Problems
____ Kidney Disease
____ Gout
____ Neck Injuries
____ Fractures (broken bones)
____ Dislocation (joint)
____ Back Injuries
____ Whiplash
____ Heart Disease
____ Cancer
____ High Blood Pressure
____ Lung Disease
____ Jaw Injuries/TMJ
____ Gastrointestinal Problems

PLEASE MARK THE FOLLOWING IF YOU HAVE RECENTLY EXPERIENCED:

____ Headaches
____ Falls
____ Tremors
____ Muscular Pain at Rest
____ Difficulty sleeping
____ Constant Pain Unrelieved
____ Dizziness
____ Balance Problems
____ Unusual Fatigue
____ Unusual Weakness
____ Blurred/Double Vision
____ Unexplained Weight Loss
____Tingling, numbness or loss of feeling
____ Unusual Skin Coloration
____ Pain with Coughing/sneezing
____ Change in Bowl and Bladder Habits
____ Shortness of Breath

PLEASE LIST ANY MAJOR SURGERIES AND HOSPITALIZATIONS

_____ DATE: _____

_____ DATE:_____

_____ DATE: _____

_____ DATE:_____

DO YOU SMOKE? YES/NO **ARE YOU PREGNANT?** YES/NO **ALLERGIES?** YES /NO

PLEASE LIST ALL MEDICATIONS YOU ARE PRESENTLY TAKING:

_____

_____

_____

PLEASE MARK THE FOLLOWING IF ANY OF THESE DIAGNOSTIC TEST HAVE BEEN PERFORMED?

____ X-Rays Date: _____ Results: _____

____ MRI Date: _____ Results: _____

____ EMG/NCV Date: _____ Results:_____

PLEASE DESCRIBE YOUR PROBLEM:

List your chief complaints in order of severity: On a scale of 0 - 10 (10 being worst)

1._____Date of Onset?_____Rating_____

How would you rate your pain: mild 0 - 3 moderate 4 - 6 severe 7 - 10

2._____Date of Onset?_____Rating_____

How would you rate your pain: mild 0 - 3 moderate 4 - 6 severe 7 - 10

3._____ Date of Onset? _____Rating_____

How would you rate your pain: mild 0 - 3 moderate 4 -6 severe 7 - 10

PLEASE CHECK THE FOLLOWING WHICH BEST SESCRIBE YOUT PAIN:

____ CONSTANT ____ INCREASING ____ NIGHT PAIN ____ DULL/ACHY PAIN

____ INTERMITTENT ____ DECREASING ____ STIFFNESS ____ SHARP PAIN

____ PAIN UPON WAKING ____ OCCASIONAL ____ STATIC

2. How would you rate your ability to perform routine daily activities:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

3. How would you rate your ability to perform the activities associated with your job:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

4. How many days since your current injury? [ ] 0-30 days [ ] 31-90 days [ ] 90+ days

I _____ have provided all of the above information to the best of my knowledge at the time of this visit and will notify this office if any information above has changes during the care of BACK TOGETHER AGAIN, P.C.

Signature:_____Date_____

BACK TOGETHER AGAIN CHIROPRACTIC

Dear Patient,

Welcome to our practice. Thank you for your confidence and trust in scheduling an appointment with our clinic. We are always dedicated to quality care for all our patients and we are always here to discuss your problems and find together the most appropriate solution. Our office policies are as follows. Please read carefully the following policies and sign below.

Patient Office Policy

Back Together Again is a cash office and payment is expected at time of service. Payment methods include check, Master Card, Visa, American Express, Debit Card, or cash.

We also provide documentation for insurance reimbursements EXCEPT FOR MEDICARE.

Appointments

Your appointment time is reserved exclusively for you, and we do our very best to make sure that we focus the entire appointment on you and your needs. If you are running late, we hope you understand that we cannot extend your appointment time as that will take away time from the patient whose appointment is booked after yours.

You should understand that when you don't show, three people get hurt: 1) yourself because you don't get the treatment you need as prescribed by the doctor 2) the therapist who now has a "vacancy" in the schedule since the time was reserved for you personally, and 3) another patient who could have been given treatment if you had given us proper notice.

Cancellation Policy

This office does not double book appointments, therefore, we have a strict cancellation/reschedule policy. If you are unable to keep your appointment please contact our office 24 hours prior to your scheduled appointment to avoid charge. The customary fee will be charged for missed or untimely cancelled appointments.

Bounced Check Fee

A $35.00 fee will be charged in addition to the original office visit for any check returned unpaid.

Scheduled Visits

Your results are obtained based on the number of visits per week not per month. Therefore, it is vital you keep to your schedule. If you must cancel, we suggest, if possible, that you reschedule for later the same day or within the same week.

Consent for Treatment

It must be noted that although the occurrence is rare you may experience an increase in pain during the first few days following your treatment, and that although equally rare, some bruising of areas treated may occur. This is a rare but normal result from pressure performed on soft tissue. I understand that the purpose of these procedures has been explained to me. My signature attests to the fact that I have read and understand the

points presented above.

Print name:_____ Date:_____

BACK TOGETHER AGAIN CHIROPRACTIC
CONSENT TO USE/DISCLOSE HEALTH INFORMATION FORM

Although Back Together Again Chiropractic is not required by law to obtain a signed consent from you for treatment, payment or healthcare operation purposes, we encourage you to sign this consent so that you are aware of our practices regarding protection of your personal health information.

Should you desire a more complete description of the permissible uses and disclosures of your protected health information, you have the right to review a Notice of Privacy Practices (the "Notice") prior to signing this consent.

The Notice is available by contacting the Privacy Officer. Please note that Back Together Again Chiropractic reserves the right to change the privacy practices described in the Notice.

By signing this consent, you agree that Back Together Again Chiropractic may use or disclose your protected health information to carry out treatment, payment, or health care operations.

You have the right to request that Back Together Again Chiropractic restrict how your protected health information is used or disclosed to carry out treatment, payment, or health care operations. However Back Together Again Chiropractic is not required to agree to such restrictions. If Back Together Again Chiropractic does agree to a restriction that you request, such restriction will be binding.

You have the right to revoke this consent in writing, except to extent that Back Together Again Chiropractic has taken action in reliance to your consent.

Acknowledgement and Agreement

I consent to Back Together Again Chiropractic sending protected health information to the insured in the event am receiving treatment but am not insured under my insurance policy. Such information may include, but not being limited to, explanation of benefits ("EOB") or invoices regarding my treatment. I understand that if I do not want such protected health information mailed to the insured, then I will notify Back Together Again Chiropractic of my objectives and will complete a request for Restriction of use and Disclosure form.

In addition, I understand and accept the risk of unintentional disclosure of my protected health information because the treatment area is an open area where I and other patients are treated simultaneously I understand that none of my protected health information may be inadvertently overheard b other patients and/or therapists. I also agree not to disclose any protected health information that I might inadvertently overhear about other patients while I am receiving treatment in the open treatment area.

I consent to Back Together Again Chiropractic releasing my protected health information to the following individuals:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

I hereby notify that I have read the provisions set forth in this consent. I nderstand and agree to the terms of this consent.

Patient's name: _____ **Date:** _____

Signature of Patient or Representative: _____