MCR CHIROPRACTIC

PATIENT INTAKE FORM (1/2)

Patient Information

Date: _____ Patient Name: _____

DOB: _____ Sex at Birth: M F Preferred Pronouns: _____

Emergency Contact: _____ Phone & Relationship to Patient: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Cell Phone: _____ Email: _____

Preferred method of contact for appointment reminders: ❍ Text ❍ Email ❍ Please do not contact

Do we have permission to leave a voice message? ❍ Yes ❍ No Other: _____

Under 18: Y N If yes, Parent/Guardian Name: _____ DOB: _____

Insurance Type ❍ Personal ❍ Workers Compensation Claim ❍ Motor Vehicle Accident

Addt'l Info.

How did you hear about us? *(ie. MD, online, friend, etc..)* _____

PCP: _____ Practice Name: _____ Phone: _____

Date of Onset: _____ *(if applicable)* Date of next MD Appt: _____

Is this an Auto Accident injury? ❍ Yes ❍ No

Insurance Information**: Primary: _____ Secondary: _____

***see verification & estimated responsibility for more detailed information*

Consent to Treat

I, the undersigned, give MCR Chiropractic my permission to evaluate and treat my injury. I further understand that in the course of recommended treatment, my condition may worsen or new symptoms may develop on rare occasions. I also understand that no guarantee or promise has been made to me concerning the results of treatment. Lastly, I understand that common areas are accessed by other patients, gym members and guests and as a result, there may be incidental contact with personal health information.

Signature: _____ Date: _____ Relationship to patient: _____

No Shows/Cancellation Policy

In order for you to have the best possible outcome from your treatment, it is essential that you attend all of your appointments. Missing scheduled appointments greatly hinders progress toward your goals and may result in delaying your recovery. ***We respectfully require a 24 hour notice for any appointment cancellation*** *which allows us the best opportunity to accommodate another patient requiring treatment.* ***We reserve the right to charge a missed visit fee if less than 24 hours notice is given*** *. Exceptions would be emergency, illness or inclement weather.*

DO NOT CANCEL if you are feeling worse or believe the treatment is not working. Please understand that your pain will fluctuate as your course of treatment progresses. Keep your appointment and discuss any changes with your provider.

DO NOT CANCEL if you are feeling better; keep your appointment in order to progress your plan of care & prepare for discharge.

Signature: _____ Date: _____ Relationship to patient: _____

PATIENT INTAKE FORM (2/2)

Ack of Notice of Privacy Practices & Release of Information

I, the undersigned, have read & understand the Notice of Privacy Practices. MCR Chiropractic reserves the right to modify the privacy outlined in this notice.

Signature: _____ Date: _____ Relationship to patient: _____

I understand that MCR Chiropractic may use or disclose my Personal Health Information (PHI) for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payments. I further understand I have the right to restrict how my PHI is used and disclosed for treatment, payment and administrative operation if I notify the practice. I also understand that MCR Chiropractic will consider requests for restriction on a case by case basis but does not have to agree to requests for restrictions.

I hereby authorize one or all of the designated parties listed below to request and receive the release of any PHI regarding my treatment, payment or administrative operations related to my treatment and payment. I also understand that the identity of the designated parties must be verified before the release of any information.

Please provide the name(s) of the individual(s) who you will allow to receive any part(s) of your health record.

Authorized Individual: _____ Phone & Relationship: _____

Authorized Individual: _____ Phone & Relationship: _____

Patient Name: _____ Date: _____ DOB: _____

Signature: _____ *if under 18* Relationship to patient: _____

Financial Policy

As a service to our patients, we will verify your benefits with your insurance company. It is, however, ***the patient's responsibility to be aware of their in-network/out of network options as well as the contractual agreement they have with their insurance company*** *per their policy.* ***It is the patient's responsibility to initiate a referral when it is required.***

Patients MUST immediately report to us any changes to their insurance plans *. Any denials in services already provided as a result of failing to report changes will be the financial responsibility of the patient. Although we make every effort to assist our patients in dealing with their insurance companies, we cannot serve as negotiators of the contract between these two parties. Ultimately, it is the patient's responsibility to resolve any insurance denials directly with their insurance company when the denial is through no fault of our practice.*

I understand and agree that insurance claim forms will be submitted to my insurance company on my behalf as a matter of convenience only and that I am responsible for all charges regardless of my existing medical coverage. I also understand that I am responsible for any out of pocket costs such as copays, deductibles, coinsurances & medical supplies. I also understand that ***copays are due at the time services are rendered*** *& any medical supplies must be paid for the same day.*

I hereby give authorization for payment of insurance benefits to be made directly to MCR Chiropractic for services rendered. In the event that my insurance company forwards payment directly to me, I will immediately deliver said payment to the clinic where services were rendered.

I understand & agree that I am wholly responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand. I further understand that by not addressing my balance beyond the second billing cycle may subject my account to collections actions. I understand and agree that if it becomes necessary for MCR Chiropractic to utilize an outside collection agency or to commence court action for the collection of any outstanding charges, I will be responsible for the outstanding balance as well as attorney fees, court costs and any other related expenses.

I agree to release of medical or other information necessary to process my claim.

I understand that any unsettled balances from a previous case must be resolved prior to returning for care.

Returned Check Policy: Any checks returned for insufficient funds will immediately be subject to a $30 processing fee in addition to the value of the check. Patients with a returned check fee will not be permitted to use this form of payment going forward for product or services.

Person Responsible for Charges: _____ _____ _____

please print *signature* *date*

MCR CHIROPRACTIC

MEDICAL HISTORY FORM

Name: _____ DOB: _____ Date: _____

Height: _____ Weight: _____

Medical History

Have you ever been diagnosed and/or treated for any of the following conditions (Mark all that apply):

CONSTITUTIONAL
- ❍ Weight Loss
- ❍ Fatigue
- ❍ Fever

EYES
- ❍ Glasses/Contacts
- ❍ Eye Pain
- ❍ Double Vision
- ❍ Cataracts

CARDIOVASCULAR
- ❍ Murmur
- ❍ Chest Pain
- ❍ Palpitations
- ❍ Fainting/Spells
- ❍ Short of Breath
- ❍ Difficulty Lying Flat
- ❍ Swelling in Ankles
- ❍ Pacemaker/Defibrillator

PSYCHIATRIC
- ❍ Anxiety
- ❍ Depression
- ❍ Mood Swings
- ❍ Difficulty Sleeping

RESPIRATORY
- ❍ Cough
- ❍ Coughing Blood
- ❍ Wheezing
- ❍ Chills

ENDOCRINE
- ❍ Loss of Hair
- ❍ Heat Intolerance
- ❍ Cold Intolerance
- ❍ Diabetes Type I or II

ALLERGIES
- ❍ Hives/Eczema
- ❍ Hay Fever

GASTROINTESTINAL
- ❍ Heartburn/Reflux
- ❍ Nausea/Vomiting
- ❍ Constipation
- ❍ Change Bowel Mvts
- ❍ Diarrhea
- ❍ Jaundice
- ❍ Abdominal Pain
- ❍ Black/Bloody Bowel Mvmts

GENITOURINARY
- ❍ Burning/Frequency
- ❍ Nightime
- ❍ Blood in Urine
- ❍ Erectile Dysfunction
- ❍ Bladder Leakage
- ❍ Abnormal Leakage

HEMATOLOGY/LYMPH
- ❍ Bruise Easily
- ❍ Gums Bleed Easily
- ❍ Enlarged Glands

SKIN
- ❍ Rashes/Sores
- ❍ Lesions
- ❍ Itching/Burning

NEUROLOGICAL
- ❍ Loss of Strength
- ❍ Numbness
- ❍ Headaches
- ❍ Tremors
- ❍ Memory Loss

CANCER
- ❍ Date of Diagnosis:
- ❍ Location:
- ❍ Status:

MUSCLE/BONE
- ❍ Joint Pain/Swelling
- ❍ Stiffness
- ❍ Muscle Pain
- ❍ Bone Pain
- ❍ Osteoporosis

Describe any other conditions or precautions: _____

Injured as a result of a fall in the past year? Y N If yes, list date of fall: _____

Have you had two or more falls in the past year? Y N If yes, list dates of falls: _____

Surgical History

Please list past surgeries/conditions/hospitalizations: ❍ Check to signify separate list attached.

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

Current Rx

Please list all medications, dosage, frequency and route : ❍ Check to signify separate list attached.

Name: _____ Dosage: _____ Frequency: _____ Route: _____

Name: _____ Dosage: _____ Frequency: _____ Route: _____

Name: _____ Dosage: _____ Frequency: _____ Route: _____

Please list any allergies that you have (i.e.; medications, latex, food, bee stings): _____

Any additional information: _____

PRESENT CONDITION

Name: _____ DOB: _____ Date of Injury/Onset: _____

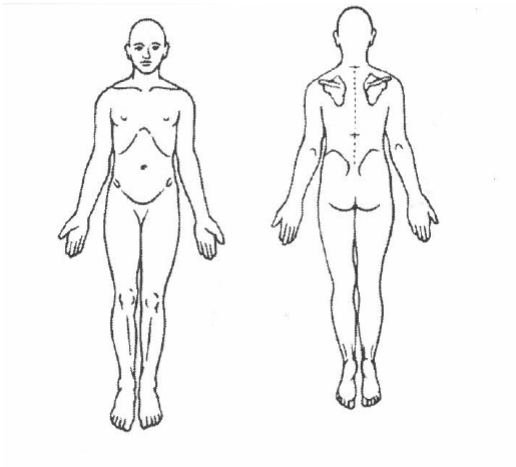
What are you seeing our provider for today? _____

Have you been previously seen by a DC for this condition? Y N *If yes, # of visits:* _____

Have you received outpatient/home care within this calendar year for any reason? Y N *If yes, # of visits:* _____

if applicable: Company/Contact Name: _____ Date of D/C: _____ PH: _____

Please localize your <u>pain</u> or <u>abnormal</u> symptoms/ sensations by marking on the body diagram below.



Condition 1: _____

Pain at best: *0 = No Pain 10 = Unbearable Pain*

0 1 2 3 4 5 6 7 8 9 10

Pain at worst: *0 = No Pain 10 = Unbearable Pain*

0 1 2 3 4 5 6 7 8 9 10

Condition 2: _____

Pain at best: *0 = No Pain 10 = Unbearable Pain*

0 1 2 3 4 5 6 7 8 9 10

Pain at worst: *0 = No Pain 10 = Unbearable Pain*

0 1 2 3 4 5 6 7 8 9 10

Nature of pain/symptoms: *(check all that apply)*

- ❍ sharp ❍ aching ❍ constant
- ❍ dull ❍ throbbing ❍ occassional
- ❍ burning ❍ shooting ❍ periodic
- ❍ other: _____

Have you experienced similar symptoms in the past?

❍ yes ❍ no

More than one episode? ❍ yes ❍ no

Was the onset of this episode:

❍ gradual ❍ sudden

Since the onset of your condition, are your symptoms:

❍ getting better ❍ worse ❍ same

Your symptoms are worse in the:

- ❍ morning ❍ afternoon ❍ night
- ❍ increased during the day ❍ same all day

What aggravates your symptoms? *(check all that apply)*

- ❍ sitting ❍ standing
- ❍ going to/rising from sitting ❍ squatting
- ❍ lying down ❍ sleeping
- ❍ walking ❍ up/down stairs
- ❍ reaching overhead ❍ coughing/sneezing
- ❍ reaching in front of body ❍ taking a deep breath
- ❍ reaching behind back ❍ looking up overhead
- ❍ reaching across body ❍ sustained bending
- ❍ household activities including_____ ❍ recreations or sports including_____
- ❍ repetitive activities ❍ stress
- ❍ other _____

What eases your symptoms? *(check all that apply)*

- ❍ cold ❍ rest ❍ sitting
- ❍ heat ❍ massage ❍ standing
- ❍ medication ❍ stretching ❍ lying down
- ❍ other: ❍ exercise ❍ nothing

_____

Does the pain wake you at night? ❍ yes ❍ no

How would you rate your general health?

❍ Excellent ❍ Good ❍ Average ❍ Fair ❍ Poor

Living situation: ❍ live alone ❍ live with family ❍ live with caregiver ❍ assisted living

Setting:

- ❍ stairs (railing) ❍ no stairs ❍ elevator
- ❍ stairs (no railing) ❍ ramp ❍ uneven ground

Any additional information: _____

_____

Signature: _____ *Date:* _____ Relation to Patient if under 18: _____