Dr. Scot Chiropractic

Patient Intake Form

(All patient information is kept confidential)

Date:_____/_____/_____

First Name:_____MI___Last Name:_____

Street Address:_____City:_____

State:_____ Zip:_____ Email:_____

Home Phone:_____ Cell:_____ Work:_____

Gender: M / F Date of Birth:_____/_____/_____

Soc. Sec.#:_____/_____/ _____

Marital Status: S M D W Spouses Name:_____

Employer:_____Phone #:_____

State:_____ Zip:_____

Insurance Company:_____

ID / Member #:_____ Group / Policy #:_____

Emergency Contact:_____ Phone #:_____

Current Physician:_____ Phone #:_____

Address:_____

City:_____ State:_____ Zip:_____

Current Medications:_____

Reason for medication:_____

Have you previously been seen by a chiropractor, & if so when?_____

How did you hear about our office?_____

Patient Informed Consent

I_____, the undersigned patient, consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to the clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform the clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Signature:_____**Date:**_____/_____/ _____

Consent for X-Ray

In the event that an x-ray is recommended, I agree that I am **NOT** pregnant and consent to X-Ray(s) being taken.

Patient Signature:_____**Date:**_____/ _____/_____

Dr. Scot Chiropractic

Scot L. Gircsis D.C.

YOUR NEIGHBORHOOD CHIROPRACTOR

Health Insurance Responsibility Form

Most insurance plans have limitations to care. Some insurance plans have serious limitations to care. It's important for you to know that all recommendations for your care are based upon your evaluation, not based on your insurance coverage. Our chiropractic office takes pride in giving our patients honest, sincere recommendations based on our experience in handling cases like yours.

Patient Name_____

Insurance Company_____

Remaining Deductible_____**Co-Pay/Co-Ins.**_____

Maximum Allowed_____ **(Visits/Dollars)**

Treatment Program_____**(Amount of visits Prescibed by Doctor)**

Insurance Covers_____

Additional Visit Expenses_____

(Any remaining service not covered by Insurance)

Patient Responsibility_____

I authorize my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dailing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing adress provided.

_____ _____/_____/_____

Patient Signature **Date**

It is important for you to know that the above listed information is an estimate of your responsibility based on our conversation with your insurance reprsentative and is not a guaranteed quote of required payments or coverage. Any questions regarding your bill should be address immediately with our financial officer.

Although we cannot guarantee that we will "cure" your problem, we can guarantee that we will treat you with respect, compassion, and caring. And...if **at any time** you are not completely satisfied with the care you received and wish to terminate your treatment program we will refund you any of your unused investment toward your health care plan.

Revised Oct. 2014

Dr. Scot Chiropractic

SCOT L. GIRCSIS D.C.
YOUR NEIGHBORHOOD CHIROPRACTOR

Dr. Scot Gircsis
Office: (614) 274-7500
Fax: (614) 274-7599

Patient Name_____ Date _____

1. When did your symptoms start: _____

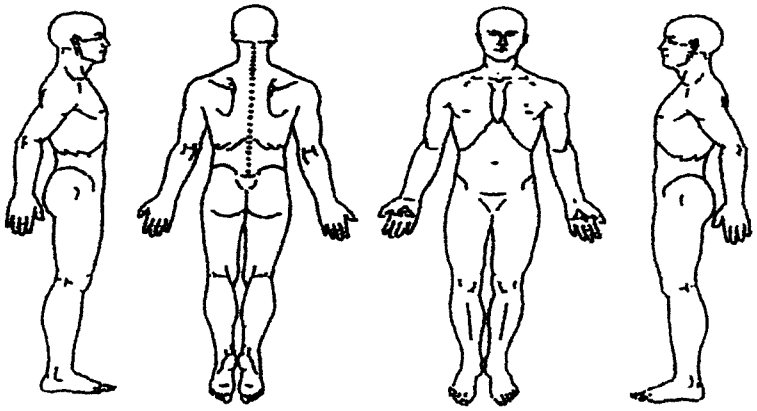
Describe your symptoms and how they began:

_____

_____

2. How often do you experience your symptoms?
- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?
- ☐ Sharp ☐ Shooting ☐ Dull ache
- ☐ Burning ☐ Numb ☐ Tingling

4. How are your symptoms changing?
- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse

5. How bad are your symptoms at their:

	None										Unbearable
a. Worst:	0	1	2	3	4	5	6	7	8	9	10
b. Best:	0	1	2	3	4	5	6	7	8	9	10

6. Which of the following is most affected because of this?
- ☐ Work ☐ Mood ☐ Chores
- ☐ Home Life ☐ Hobbies ☐ Athletic / Sports

7. What activities make your syptoms worse: _____

8. What activities make your symptoms better: _____

9. Who have you seen for your symptoms?
☐ No One ☐ Medical Doctor ☐ Other
☐ Other Chiropractor ☐ Physical Therapist

a. When and what treatment? _____

b. What tests have you had for your symptoms
and were they performed? _____
☐ Xray date: ☐ Medical Doctor ☐ Other
☐ Other Chiropractor ☐ Physical Therapist

10. Have you had similar symptoms in the past? 1) Yes 2) No

a. If you have recieved treatment in the past for the same or similar symptoms, who did you see?
1) This Office 3) Medical Doctor 5) Other
2) Other Chiropractor 4) Physical Therapist

11. What is your occupation?
1) Professional/Executive 4) Laborer 7) Other
2) White Collar/Secretarial 5) Homemaker
3) Tradesperson 6) FT Student

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?
1) Full-time 3) Self-employed 5) Off Work
2) Part-time 4) Unemployed 6) Other

12. What describes the nature of your symptoms? *(select all that apply)*
1) Reduce symptoms 3) Explanation of condition/treatment 5) How to prevent this from occuring again
2) Resume/increase activity 4) Learn how to take care of this on my own

Patient Signature _____ Date: _____

HIPPA Declaration

The Practice:

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI
(b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which provided for under federal law
(c) Is required to abide by the terms of the Privacy Notice
(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains
(e) Will distribute any revised Privacy Notice to you prior to implementation
(f) Will not retaliate against you for filing a complaint

Patient Communications:

Health Insurance Privacy Act 1996 requires we inform you of the following government stipulations in order for us to contact you with educational and promotional items in the future via email, U.S. mail, telephone, and/or pre-recorded messages. We **WILL NOT** ever share, sell, or "SPAM" your personal contact information.

Marketing is any communication about a product or service that encourages recipients to purchase or use the product or service. Communication can be defined as Voice Blasts, Email, and numerous marketing pieces. Communications to describe health-related products or services, or payment for them, provided by or included in a benefit plan of the covered entity making the communication

(a) Communications about participating providers in a provider or health plan network, replacement of or enhancements to a health plan, and health-related products or services available only to a health plan's enrollees that add value to, but are not part of, the benefit plan.
(b) Communication for treatment of the individual
(c) Communications for case management or care coordination for the individual, or to direct or recommend alternative treatments, therapies, health care providers, or care settings to individuals

If you have any questions about this notice please contact the following person:
Effective Date of this Notice:_____
Contact Person: _____
Phone Number:_____

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of this notice, and my understanding and my agreement to its terms.

_____ _____
PATIENT Date

☐ Patient refused to sign ☐ Patient unable to sign for the following reason:

_____