Elemental Chiropractic
1640 Old Apex Road
Cary, NC 27513

Elemental Chiropractic Patient Intake Form

Patient Name _____Date_____

Address _____

City _____ State _____ Zip Code _____

Phone (_____) _____-_____ Date of Birth _____/_____/_____

Email _____

Sex: M F Job Description _____

HEALTH HISTORY

Surgeries: _____
_____

Medical Conditions: _____
_____

Injuries/Hospitalizations: _____
_____

Family History: (Mark all that apply)

Arthritis:	___Parent	___Sibling
Cancer:	___Parent	___Sibling
Diabetes:	___Parent	___Sibling
Heart Disease	___Parent	___Sibling
Hypertension	___Parent	___Sibling
Stroke	___Parent	___Sibling
Thyroid	___Parent	___Sibling

In the Last 6 Months: (mark all that apply)
___Fatigue for unknown reasons
___Drastic Weight loss/gain
___Change in appetite/thirst
___Fevers/Chills/Sweats
___Pain that doesn't change with position
___Pain that wakes you up at night
___Bruising/Bleeding easily

Please list all current medications/Supplements being taken _____
_____

Do you experience headaches? (circle) Yes No
If so, please describe how often and how severe_____
_____

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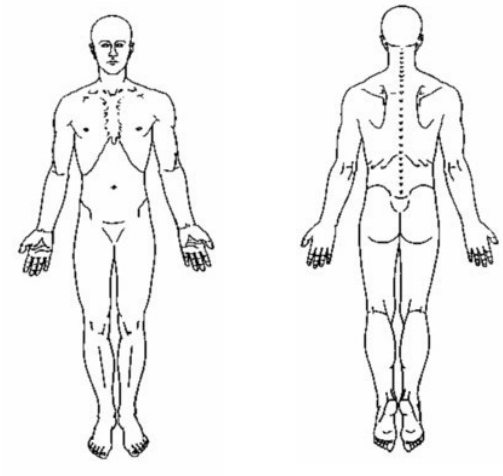
CURRENT COMPLAINT

Where is your pain? _____

Indicate on the body diagram where you are experiencing the following symptoms:



Average Pain Intensity: (please circle)

Last 24 hours:

no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week:

no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

How did your symptoms begin?

_____

How long have you had your symptoms? _____

How often do you experience your symptoms? (Circle)

Constantly (76-100% of the day) Frequently (51-75% of the day) Occasionally (26-50% of the day) Intermittently (0-25% of the day)

What describes the nature of your symptoms?

___Sharp ___Dull Ache ___Numb ___Shooting
___Burning ___Tingling ___Throbbing

Does your pain radiate? If yes, where? _____

Activities of Daily Living - Please check if you have pain or difficulty performing the following:

□ Change of Position □ Driving □ Extended Computer Use □ Stairs
□ Bending □ Walking □ Exercising □ Sleep
□ Sitting □ Standing □ Housework □ Work
Other_____

My pain/symptoms have previously been made better by: (Check all that apply)

□ Chiropractic □ Physical Therapy □ Massage □ Advil/Tylenol □ Heat □ Ice
□ Rest □ OTC Pain Meds □ Exercise □ Stretching □ Nothing improves my symptoms
□ Other: _____

I would be interested in:

___ Dry Needling ___ Chiropractic Care
___ Supplement/Vitamin Suggestions ___ Cupping

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PAYMENT POLICY

Thank you for choosing Elemental Chiropractic as your Chiropractic provider. We are committed to providing you with quality and affordable health care. We want to be clear about our policies in this clinic. Please read the following and let us know if you have any questions. A copy will be provided to you upon request.

1. INSURANCE. We participate in most insurance plans, including Medicare, BCBS, Cigna, and Medcost. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your coverage. If your insurance company requires a referral, it is your responsibility to provide us with a referral dated the day of your first visit from your primary care physician prior to your first visit. We are only able to provide a summary of your chiropractic benefits.
2. CO-PAYMENT AND DEDUCTIBLES. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help is in upholding the law by paying your co-payment at each visit.
3. PROOF OF INSURANCE. All patients must complete our patient information form before seeing the provider. We must obtain a copy of your most current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
4. CLAIM SUBMISSION. We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.
5. CONVERAGE CHANGES. If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.
6. CASH PAYMENT. We are enrolled in ChiroHealth USA (CHUSA) that allows us to provide reduced fees for our patients who are uninsured or do not wish to use their insurance and pay out of pocket. It costs $49 to enroll for the year into this program, and all of our practice members pay at the time of service or follow a treatment plan with a payment schedule. If payment is not rendered at the time of service, the patient is expected to remit payment within 30 days of the patient visit. All balances remaining unpaid after 30 days may be turned over to a collection agency.
7. MISSED APPOINTMENT. Our policy is to charge $25.00 after one missed appointment not cancelled 24 hours in advance. The charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regular scheduled appointments.

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I certify that I am the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition/minor child, as the doctor sees fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. If I do not show up for a scheduled appointment, I understand that it is my responsibility to pay a missed appointment fee. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

I have read and understood the payment policy and agree to abide by its guidelines.

_____ _____

Signature of patient or responsible party Date

Authorization for care of a minor

I hereby authorize this clinic and it's Doctor(s) to administer care as they deem necessary to my son/daughter/ward (upon approval of parent or guardian)

Signed:_____ Witnessed:_____ Date:_____