Active Life Chiropractic
Nichole A Lehman, DC
1900 E Market St, Suite, 2, York, PA 17402
Phone: York (717) 751-0500 Fax: (717) 814-5407
ActivelifechiroPA@gmail.com

Patient Intake Form

Title ____Dr ____Mr ____Miss ___Mrs ____Ms Gender ___Male ___Female Date _____/ _____/ _____

First Name _____ MI _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____ SSN _____-_____-_____

Date of Birth _____ / _____ / _____ Age _____

Race (circle one) American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White Other Declined

Ethnicity (circle one) Hispanic or Latino Not Hispanic or Latino Declined

Preferred Language English Spanish Other_____

Marital Status Married Single Divorced Widowed Other_____

Employment Status Employed FT/ PT Student FT/PT Retired Homemaker Unemployed Disabled

Employer Name_____

Address _____ City _____ State _____ Zip _____

Job Title _____

PAYMENT AND INSURANCE INFORMATION

Will you be using any of the following? (Circle One)

Insurance Self-Pay Worker's Compensation Personal Injury/Auto Other _____

Primary Insurance _____

Policy Number _____Group#_____

Relation to Insured Self / Spouse / Parent / Child / Other

Insured's Name _____ Gender M / F

Address _____ City_____

State _____ Zip _____ DOB _____ / _____ / _____

Secondary Insurance _____

Policy Number _____Group#_____

Relation to Insured Self / Spouse / Parent / Child / Other

Insured's Name _____ Gender M / F

Address _____ City_____

State ____ Zip _____ DOB _____ / _____ / _____

Emergency Contact _____ Relationship _____

Phone Numbers _____

Primary Care Doctor/Practice _____ Phone _____

How did you hear about our office? _____

Signature _____ Date _____/ _____ / _____

Your Name_____ DOB _____ Today's Date_____

Symptoms and Present State of Health

Present Complaint/Reason for seeking care in this office _____

When did your problem begin? _____ How did your problem/complaint begin? _____

How would you describe your discomfort? (circle all that apply) Sharp Dull Ache Burning Pinching Stiff

Constant Intermittent Other _____

Do your symptoms radiate, shoot or travel in your body? Where? _____

Are you experiencing numbness/tingling in any area of your body? Where? _____

Since it began, is your problem: Same Better Worse

What aggravates or makes your problem worse? _____

What lessens or makes your problem better? _____

Is this problem worse during certain times of the day? _____

Does this condition interfere with (circle all that apply) Work Sleep Routine Other_____

Please list any other health practitioners you have seen for this condition and when seen

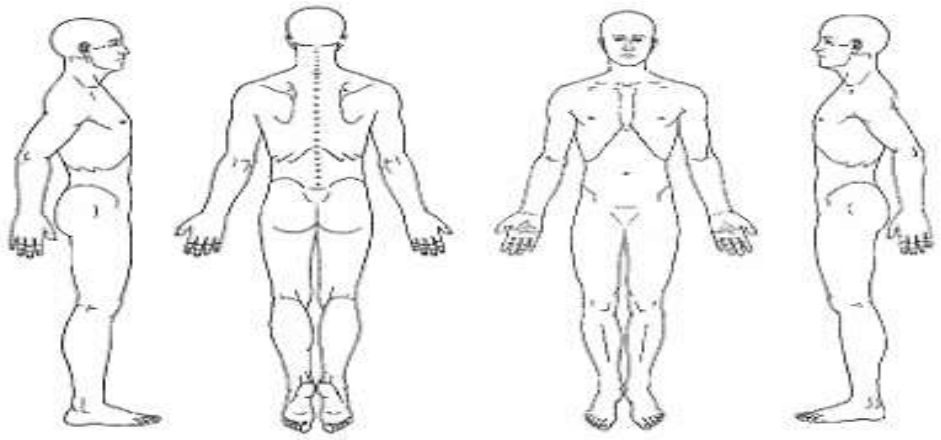
_____

Any home remedies _____ Do they help? _____

Please rate your pain by circling the number on the scale

(No complaint/ pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Pain imaginable)

Using the symbols below, mark on the pictures where you feel the pain.



Are you under medical care for any condition? If yes, please explain _____

What medications are you taking and for how long? _____

What Vitamins/Supplements/Hers are you taking? _____

Please list any surgeries you have had and when _____

Is there a family history of: Heart Disease Arthritis Cancer Diabetes Stroke Other

If yes, please explain _____

Patient Name: _____ **DOB:** _____

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
__Convulsions
__Dizziness
__Fainting
__Loss of Balance
__Fatigue
__Depression
__Headache
__Nervousness
__Irritability
__Tension
__Numbness

MUSCLES & JOINTS
__Low Back Pain
__Pain between shoulders
__Neck problems
__Arm or Hand problems
__Leg or Foot problems
__Jaw/TMJ problems
__Painful joints
__Stiff joints
__Sore muscles
__Weak muscles
__Walking problems
__Sprains/Strains
__Broken Bones
__Scoliosis

CARDIOVASCULAR
__High Blood Pressure
__Heart Attack
__Pain over the heart
__Poor Circulation
__Rapid Heart Rate
__Slow Heart Rate
__Strokes/TIA's
__Swelling in Ankles
__Varicose Veins
__Cold Feet/Hands

MENTAL/EMOTIONAL
__Anxiety
__Depression
__Anger/Aggression
__Attention Deficit
__Other_____

EAR/NOSE/THROAT
__Earache
__Enlarged Thyroid
__Frequent Colds
__Hay Fever
__Nasal Blockage/Deviated Septum
__Nose Bleeds
__Pain Behind Eyes
__Poor Vision
__Sinusitis
__Sore Throats
__Tonsilitis

GASTRO-INTESTINAL
__Stomach upset
__Frequent Belching/Gas
__Colon Problems
__Constipation
__Excessive Hunger
__Excessive Thirst
__Gall Bladder/Liver problems
__Nausea
__Abdominal Pain
__Ulcer
__GERD/Reflux/Heartburn
__Poor Appetite
__Poor Digestion
__Foods Not Fully Broken Down
__Vomiting
__Vomiting Blood
__Black Stool
__Bloody Stool
__Coating on Tongue
__Foul Breath/Halitosis
__Diarrhea
__IBS
__Crohn's
__Alternate Constipation/Diarrhea
__Loss of Smell or Taste
__Overly Sensitive to Smells

HABITS
__Smoking, what kind and how much _____
__Alcohol drinks/week_____
__Caffeine-Coffee/Tea/Energy Drinks Amount_____
__Stress Level Low Moderate High
__Exercise _____ Days/week What type of exercise_____

RESPIRATORY
__Asthma
__Chronic Cough
__Emphysema
__Spitting Blood
__Spitting Phlegm
__Allergies

GENITO-URINARY
__Blood in Urine
__Frequent Urination
__Urinary Tract Infections
__Kidney Infection
__Painful Urination
__Prostate Problems
__Loss of Bowel or Bladder Control

SKIN CONDITIONS
__Acne
__Boils
__Bruise Easily
__Eczema/Rash/Dermatitis
__Hives
__Itching frequently
__Sensitive Skin
__Dry Skin
__Hair Loss
__Too much hair

WOMEN
__Birth Control_____
__Cramps/Backache with Menstrual Cycle
__Excessive Flow
__Irregular Cycle
__Hot Flashes
__Miscarriage
__Infertility
__Painful Periods
__Vaginal Discharge
__Breast Pain
__Breast Lumps
__Fibrocystic Breasts
__# of Pregnancies _____
__# of Children_____
__Menopause, when started _____

MEN
__Testicular Problems/Pain
__Erection Difficulties
__Prostate Problems

Daily Water Intake _____

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

PATIENT SIGNATURE_____ **DATE** _____

Active Life Chiropractic
FINANCIAL POLICY

Nichole Lehman, DC /1900 E. Market St., Suite 2, York, PA 17402
Phone: (717) 751-0500 Fax: (717) 814-5407

Nichole Lehman, DC / Active Life Chiropractic believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

PAYMENT: Payment is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. We do ask for a copy of an ID card or driver's license due to the many cases of identity theft.

INSURANCE: We are participating providers with several insurance plans. We will file all these insurance claims. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed and are responsible for the balance in full. If we later receive payment for your insurer, we will refund any overpayment to you.

If **Nichole Lehman, DC / Active Life Chiropractic** is not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, you are expected to pay charges due at the time of service. Our office will provide you with a receipt that you may submit to your insurance company to request reimbursement. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

Patients who insist on "day of" urgent/emergent scheduling or care after hours or on days the office is closed may be assessed an additional urgent care or after hours fee. These fees will be billed to your insurance carrier or collected as part of the office charges for self pay patients.

LATE CHARGES: Invoices are due and payable upon receipt. There will be a $15.00 rebilling charge on each monthly statement issued after 30 days. If your account remains delinquent after 3 billing cycles, your account will be turned over to collections.

RETURNED CHECKS: Returned checks will incur a $30.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30.00 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $30.00 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in York County.

ACCOUNTING PRINCIPALS: Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

FORMS FEES: Completing insurance forms, copying medical records, etc., requires office staff time and time away from patient care for our doctor. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Base form charges are $25.00 per occurrence plus any applicable postage or notary fees. Postage is additional and payment is required in advance. Copying fees for Medical Records that are not based on a flat-rate charge are $1.46 per page for pages 1 through 20, $1.08 per page for pages 21 through 60, and $0.36 per page for pages 61 and up in accordance with the Department of Health Medical Records Fees. Active Life Chiropractic will have 15 business days in which to copy records before making them available for patient to pick up, and these 15 days will commence after payment for copying has been received and after patient has signed the form authorizing records' release.

Active Life Chiropractic
FINANCIAL POLICY

BILLING OFFICE: If you have questions in regard to any of your billing statements, our staff at Active Life Chiropractic is available to assist you on Mondays, Wednesdays or Fridays. **Call (717) 751-0500.**

RESPONSIBILITY FOR PAYMENT: I understand that I, personally, am financially responsible to **Nichole Lehman, DC / Active Life Chiropractic** for charges not covered by the assignment of insurance benefits.

CANCELLATIONS OR MISSED APPOINTMENTS: If you do not cancel your appointment at least 24 hours before, or if you no-show, we may assess you a $25.00 missed appointment fee. New patient appointments will be subject to a $100.00 missed appointment fee. If a new patient misses two new patient appointments, you will no longer be accepted into the practice.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign, transfer, and set over directly to **Nichole Lehman, DC / Active Life Chiropractic** sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic. I authorize Nichole Lehman, DC / Active Life Chiropractic to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Nichole Lehman, DC / Active Life Chiropractic. I authorize Nichole Lehman, DC / Active Life Chiropractic to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

INSURANCES WE DO NOT ACCEPT: I understand that I, personally, am financially responsible to **Nichole Lehman, DC / Active Life Chiropractic** for payment of charges at the time of service and that Nichole Lehman, DC / Active Life Chiropractic will offer to provide me with a receipt that I may use to submit to my insurance company to request direct reimbursement for any applicable services.

SELF PAY PATIENTS: Our office has reasonable rates for all Point of Service (POS) patients. Patients who are POS are required to pay at the time of service as per insurance regulations. Charges for supplies and Quest Lab tests are due and payable upon receipt. Nichole Lehman, DC / Active Life Chiropractic does not make payment arrangements or extend credit. All services and supplies are expected to be paid in full at the time of service.

RELEASE OF INFORMATION: I hereby authorize and direct **Nichole Lehman, DC / Active Life Chiropractic** to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

COLLECTION FEES: I understand that in the event my account is placed in collection status, any additional fees incurred due to this will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

DIVORCED PARENTS of PATIENTS: By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

I have read and understand the practice's financial policy and I agree to be bound by its terms.
I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____
Signature of Patient (or Guarantor, if applicable) Date

_____
Please print the name of the **patient.**

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INFORMED CONSENT

To The Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign anything that is unclear.

The Nature of the Chiropractic Adjustment: The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use those procedures to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment: AS a part of the analysis, examination and treatment, you are consenting to the following procedure: spinal manipulative therapy, range of motion testing, muscle strength testing, ultrasound, radiographic studies, palpation, orthopedic testing, postural analysis, hot and cold therapy, vital signs, basic neurological testing, electrical muscle stimulation, traction, decompression, exercise and stretches.

The Material Risks Inherent in Chiropractic Adjustment: As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strains, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for 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 Probability of Those Risks Occurring: Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during the examination and any X-rays. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The Availability and Nature of Other Treatment Options: Other treatment options for your condition may include: self-administered, over-the-counter analgesics and rest, medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers, hospitalization and surgery. If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The Risks and Dangers Attendant to Remaining Untreated: Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Nichole Lehman, DC, and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient's Name (Print) _____

Patient's Signature _____ Date _____

Signature of Parent or Guardian (if a minor)_____ Date _____

Authorized Facility Signature _____ Date _____

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Patient Name:_____ **DOB:**____/____/____

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

HIPAA NOTICE OF PRIVACY PRACTICES

I, the undersigned, have read the *HIPAA Notice of Privacy Practices* policy of Active Life Chiropractic and agree to its terms. I am also acknowledging that I have read and/or have been offered a copy of this notice, and have received a copy upon my request.

_____ _____

Patient Signature Date

_____

Parent/Guardian Signature (if patient is under 18 years of age)