New Patient Intake Form

PATIENT INFORMATION

Name: _____ Birthday (M/D/Y): _____ Age: _____ Sex: _____

Address: _____

(Street) (City) (Postal Code)

Home Ph. #: _____ Cell: _____ Email: _____

Marital status: _____ # of Children: _____ Occupation: _____

Emergency Contact Name: _____ Relationship to you:_____

Emergency Contact Phone: _____

Can The Homeplace use your email address to contact you concerning your care? Yes ☐ No ☐

Can The Homeplace use your phone number to text you regarding appointment and clinic information? Yes ☐ No ☐

How did you hear about this clinic: ☐ Walk by ☐ Website ☐ Flyer ☐ Newspaper

☐ Referral: _____ ☐ Other: _____

Primary Care Doctor: _____ Phone Number: _____

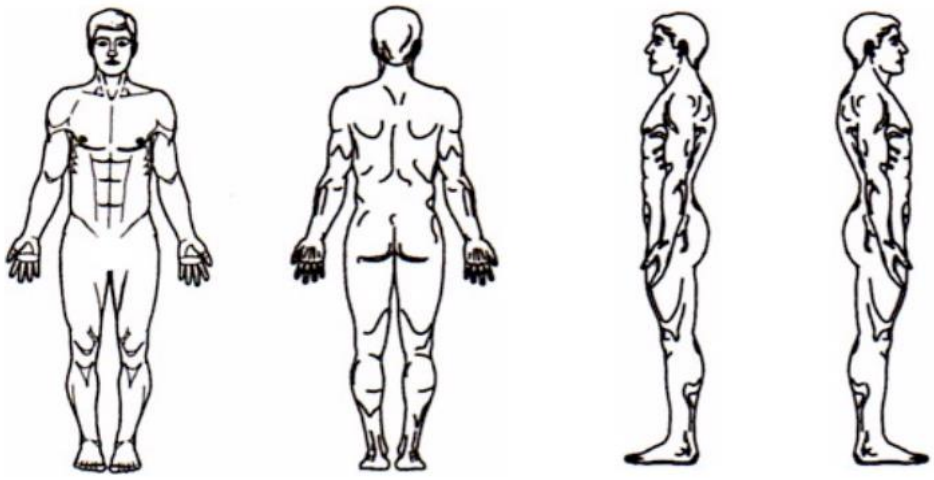
If needed, may we contact your primary care doctor for labs, x-rays, test results, etc? Yes ☐ No ☐

PRIMARY PROBLEM

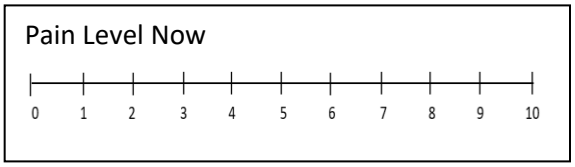
Please describe your main reason for seeking care today:

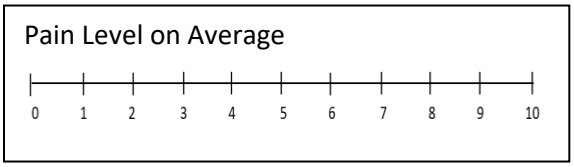
1. Is this visit related to a vehicle accident or work-related accident? ☐ Yes ☐ No
2. Have you had a similar problem in the past? ☐ Yes ☐ No
3. How would you describe the sensation of your pain/problem: Sharp Shooting Numbness Tingling Dull Ache Burning Throbbing Other: _____
4. Draw on the body chart below to mark the areas of your complaint(s). Use the following letters to indicate the type and location of your sensations.

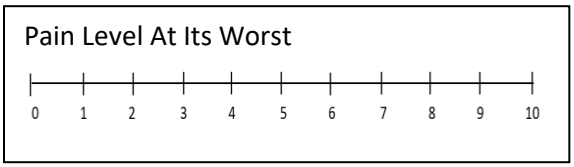
A – Ache B – Burning N – Numbness P – Pins and Needles S – Stabbing O – Other



5. Use the lines below to mark your pain as it is right now; when it's at its best; when it's at its worst, and what it is on average. Zero means there is no pain at all, 10 is the worst pain possible.







PAST MEDICAL HISTORY

Please complete the following. If you need more space, use

1. List all current prescription and over-the-counter medications, along with dose and how long you've been taking them:

2. List any past surgeries and hospitalizations. Include year and brief description:

3. List past traumatic events or accidents and the year in which they occurred:

4. List all vitamins, herbs, or other supplements you're taking. Include dose, how often you take it, and how long you've been taking it:

5. List vaccinations you've had in the past 5 years:

6. Please list any major illnesses you've had (childhood and adult):

7. Do you have any synthetic joints, metal implants or devices? ☐ Yes ☐ No

8. Are you currently pregnant? Yes ☐ No ☐ If yes, please provide estimated due date and how many weeks along you are.

9. Is there anything else about your history or current condition that you feel is important to mention?

IMAGING/LAB WORK

On the next page, describe any X-rays, CT scans, MRIs, or lab work you've had in the past year. *If you have access to your report or a copy of the images, please bring them with you to your appointment.*

Description: _____

Description: _____

Description: _____

REVIEW OF SYSTEMS

Please write **C** for current on any conditions you have now and **P** for past for any conditions you've had in the past. If none apply, please check "None of the Above."

_____ Allergies	_____ Anxiety/nervousness	_____ Heart problems
_____ Arthritis	_____ Depression	_____ Chest pain/angina
_____ Cancer/Tumor	_____ Dizziness	_____ Difficulty breathing
_____ Diabetes	_____ Ear problems	_____ Pleurisy/pneumonia
_____ Liver problems	_____ Eye problems	_____ Chronic cough
_____ Hepatitis	_____ Headaches (sudden?)	_____ Hoarseness
_____ Kidney problems	_____ Head injury/concussion	_____ Varicose veins
_____ Gall bladder problems	_____ Fractures/dislocations	_____ Constipation or diarrhea
_____ Ulcers	_____ Foot trouble	_____ Abnormal stools
_____ Thyroid problems	_____ Paralysis	_____ Blood in urine/urinary leakage
_____ Lumps on breast	_____ High/low blood pressure	_____ Menstrual cycle problems
_____ Problems sleeping/night pain	_____ Excessive fatigue	_____ Unexplained weight loss or gain

☐ None of the Above

Patient Disease History

_____ Cancer

_____ Diabetes

_____ Heart attack

_____ HIV/AIDS

_____ Stroke

☐ None of the above

Family History (list which family member had it)

☐ Cancer: _____

☐ Connective Tissue Disorder:_____

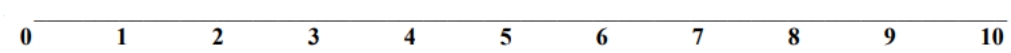
☐ Heart Disease: _____

☐ Stroke/TIA: _____

☐ None of the Above

SOCIAL AND LIFESTYLE HISTORY

1. On a scale of 0 to 10 with 0 being no stress and 10 being the highest level of stress possible, how would you rate your stress level?



2. On average, how many hours of sleep do you get each night?
3. Do you feel rested when you wake up?

4. Do you participate in any physical activities on a weekly basis?

☐ Walking ☐ Running ☐ Swimming ☐ Lift weights ☐ Cycling ☐ Other_____

5. Are there any healthy activities/hobbies you are interested in beginning?

6. How many servings of fruit and vegetables do you eat each day?

○ 0 ○ 1-2 ○ 3-4 ○ 5-7 ○ More than 7

7. How many glasses of water do you drink a day?

○ 0 ○ 1-2 ○ 3-4 ○ 5-7 ○ More than 7

8. How many caffeinated products do you consume per day?

○ 0 ○ 1-2 ○ 3-4 ○ 5-7 ○ More than 7

9. How many sugary beverages do you drink a week?

○ 0 ○ 1-2 ○ 3-4 ○ 5-7 ○ More than 7

10. How many alcoholic beverages do you drink a week?

○ 0 ○ 1-2 ○ 3-4 ○ 5-7 ○ More than 7

11. Do you currently or have you ever used tobacco products? ☐ Yes ☐ No

How many per day? _____ For how many years? _____

12. Do you currently or have you ever used recreational drug ☐ Yes ☐ No

13. Healthy habits are an important part of reducing pain. How committed are you to spending 10 to 15 minutes a day performing activities that will enhance your results?

☐ Not interested at all ☐ May do it if I can find the time ☐ I will do it most of the time but have other priorities ☐ Fully committed to doing it, no matter what

I certify that the above medical information is correct and complete to the best of my knowledge.

Patient Signature: _____ Printed: _____Date:_____

Guardian Signature: _____ Print Name: _____Date: _____

Electronic Signatures. Each party agrees that the electronic signatures, whether digital or encrypted, of the parties included in this Agreement are intended to authenticate this writing and to have the same force and effect as manual signatures. Delivery of a copy of this Agreement or any other document contemplated hereby bearing an original or electronic signature by facsimile transmission (whether directly from one facsimile device to another by means of a dial-up connection or whether mediated by the worldwide web), by electronic mail in "portable document format" (".pdf") form, or by any other electronic means intended to preserve the original graphic and pictorial appearance of a document, will have the same effect as physical delivery of the paper document bearing an original or electronic signature.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I do hereby affirm that I have received a copy of the privacy policy of The Homeplace Chiropractic, LLC. If I have any questions or wish to exercise my rights regarding my personal health information I will contact the privacy officer. In addition, I authorize The Homeplace and its staff to communicate protected health information through the use of phone, voice mail, text messages, and personal communication, i.e. birthday cards, thank you notes, etc., as well as including electronic communication such as announcements or newsletters. This release will expire six (6) years from the date of my last visit to The Homeplace Chiropractic.

Patient/Guardian Initials: _____

ACKNOWLEDGEMENT OF NUTRITIONAL DISCLAIMER

By signing this document, I signify my understanding that Dr. Laughlin/The Homeplace Chiropractic, LLC do not treat disease with nutrition. If Dr. Laughlin recommends nutritional or dietary changes, including the use of vitamins, herbs, or nutritional supplements, I understand that she is supporting my body's function, structure, and/or deficiencies and not treating disease.

Patient/Guardian Initials: _____

CONSENT TO TREATMENT/FINANCIAL RESPONSIBILITY & ASSIGNMENT OF BENEFITS

I voluntarily consent to receive healthcare services that may include diagnostic procedures, examinations, and treatment. The patient examination and treatment process includes important tests and maneuvers that require movement, exertion, and balance control and may result in worsening of symptoms, muscle strain, and falling. I accept these risks and agree that I will provide correct answers and information and I will notify The Homeplace if there has been a change in any of my answers or information.

I hereby assign, transfer, and set over to The Homeplace Chiropractic, LLC all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient Signature: _____ Date:_____

Patient Name Printed: _____

Guardian Signature: _____ Date: _____

Guardian Name Printed: _____

APPOINTMENT AND CANCELLATION POLICIES

New patient visits, existing patient exams, and maintenance visits for existing patients may be scheduled online up to one hour prior to the appointment time if space is available. Acute care appointments will be scheduled by the front desk after an exam has been performed.

Cancellations and re-scheduled appointments will be subject to a $25 cancellation charge if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for an appointment, you may be asked to reschedule.

INSURANCE BILLING

We are a participating Medicare provider but are not currently in-network with any other insurance companies. We will help prepare the patient's insurance forms to assist with reimbursement. If your insurance covers chiropractic care and you plan to request reimbursement, please present your insurance card at check-in and we will help you with the necessary documentation for submission.

All health services provided are charged directly to the patient and he/she is responsible for payment of all physician services. **Payment is due at the time of service unless a payment program has been arranged. Please refer to our detailed financial policy for more information.**

GOOD FAITH ESTIMATE

In accordance with the No Surprises Act, a personalized Good Faith Estimate will be provided to you. Information on the No Surprises Act is available in the intake packet, is posted in the office, and is available on our website. If you have any questions, please contact the front office at (970) 673-8486.

CHECKS RETURNED FOR SPECIAL HANDLING

A $25.00 service charge will be charged for any checks returned for any reason for special handling.

DISCOUNT POLICIES

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies:

Our clinic has established a single fee schedule that applies to all patients for each service provided.

You may be entitled to a network or contractual discount under the following circumstances:

- If we are a participating provider in your health plan.
- If you are covered by a State or Federal program with a mandated fee schedule.
- We are a network provider in a DMPO that you may join. Patients who are uninsured, or underinsured, will be entitled to network discounts similar to our insured patients. Membership is $49.00 a year and covers you and your dependents. Ask our team for more information.
- Patients who meet state and or federal poverty guidelines or other special circumstances outlined in our "Hardship Policy" may be offered a discount for a period of time as determined by the clinic. Verification will be required.

As part of our compliance plan, as of February 1, 2023 our office will be unable to extend any type of discounts other than those listed above. Detailed financial policies are available in the office upon request.

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