DANIELS CHIROPACTIC OFFICE

CONFIDENTIAL PATIENT INFORMATION

TITLE: (i.e. Mr., Mrs., Dr.) _____LAST NAME _____ FIRST _____MIDDLE_____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CELL PHONE _____ - _____ - _____ WORK PHONE _____ - _____ - _____ EXT X_____

HOME _____ - _____ -_____

EMAIL: _____@ _____.___ (for announcements i.e. closed for vacation, etc. Not for advertisements)

BIRTHDATE ____/____/_____ AGE _____

STATUS: (PLEASE CHECK ONE) ___ MARRIED ___SINGLE ___OTHER (Divorced, Widow, Widower)

EMPLOYER _____ ___ FULL TIME ___ PART TIME ARE YOU A STUDENT? ___ FULL ___PART TIME

PRIMARY CARE PHYSICIAN _____

DO YOU HAVE TWO HEALTH INSURANCE POLICIES? YES NO

IF WE EVER NEED TO LEAVE A MESSAGE ON YOUR VOICEMAIL (residence/cell) MAY WE DO SO? YES NO

IS YOUR CHIEF COMPLAINT DUE TO AN ON THE JOB OR AUTO / NON AUTO INJURY? Y / N

EMERGENCY CONTACT _____ PHONE NUMBER (_____) - _____ - _____

WHO REFERRED YOU TO THE OFFICE?_____

PAYMENT (Co-Pays, Deductibles, etc…)

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and *not* the insurance carrier and the doctor. Furthermore, I understand that Daniels Chiropractic Office will prepare necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Daniels Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care and treatment, any fees for professional services rendered me will be immediately due and payable**. I understand that $10 will be charged to my account should I fail to show up for an appointment *without advanced notification* and therefore *agree to call and inform the office* if I am not be able to make any appointment(s). I also understand that should my outstanding account balance (copays, coinsurances, deductible or any out of pocket care) go unpaid for (90) ninety days after the first mailed billing, the balance due will be considered in default and will be handed over to the office collections process (agency, attorney or small claims court). If the account proceeds to any third party for collections (agency, attorney or small claims), I will be charged an office processing fee of $25.00 (plus court costs if applicable).** I agree to allow Daniels Chiropractic Office to keep a form of payment on file (credit card, HSA or flexible debit card) should my insurance have a deductible and agree to have Daniels Chiropractic Office charge said card once the insurance claim processes demonstrating a deductible is to be paid.

X_____ ____/____/_20_____
Signature of patient or legal guardian if under 18 years of age Date

I ACKNOWLEDGE RECEIPT OF HIPPA (Privacy) POLICY (last three pages or see website): x_____
Federal Law mandates a PRIVACY POLICY be maintained and shown to you. This policy is underneath the intake forms you are filling out on the clip board as well as our website at www.DanielsChiropracticOffice.com. All information stays between you, this office and your insurance. If any of your information needs to go outside this circle, you will be notified and only with your permission (i.e. informing another doctor of your condition for the purposes of referring you out).

IT IS IMPORTANT FOR YOU TO INFORM THE OFFICE WHEN YOU RECEIVE A NEW INSURANCE CARD FROM YOUR HEALTH INSURANCE COMPANY REGARDLESS IF IT IS WITH THE SAME COMPANY. RECEIVING A NEW CARD INDICATES YOUR COVERAGE HAS CHANGED. YOU WILL BE RESPONSBILE FOR ANY INCREASE IN COPAYS / DEDUCTIBLES SHOULD YOU NOT INFORM THE OFFICE. _____ (INITIALS)

INFORMED CONSENT: CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (the patient named below, for whom I am legally responsible) by ***Dr. Brian Daniels*** who now or in the future will be treating me in this office.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including but not limited to sprains and strains, fractures, disc injuries, strokes, dislocations and general aggravation of inflammatory conditions. I understand that I will have an opportunity to discuss with the doctor or other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the doctor will perform an exam in order to minimize any risk of care. However, I do not expect the doctor to anticipate and explain all risks and complications. I therefore wish to rely on the doctor to exercise judgement during the course of the procedure, which the doctor feels at the time, based upon the facts as then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the procedures. I intend for this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

X_____ _____
Patient Signature Date

_____ _____
Parent or Legal Guardian (if patient is under 18 years of age) Date

INSURANCE AUTHORIZATION FORM

I understand and agree that all fees for professional services rendered on my behalf are my personal responsibility and are due and payable at the time services are performed unless other arrangements are made. The event that the insurance company should pay me for services due this office, I will immediately settle the outstanding bill with this office.

Signed:**X**_____Date:_____

RELEASE OF MEDICAL INFORMATION

I hereby authorize and direct Brian Daniels, D.C. d/b/a Daniels Chiropractic Office to release all medical and financial information necessary to process this claim and to inform my Primary Care Physician or other physician should I need to be referred out for purposes of further evaluation or clinical information update.

Signed:**X**_____Date:_____

AUTHORIZATION TO PAY

I hereby authorize and direct the immediate payment of said benefits directly to the Doctor and request and direct that my insurance company pay to said Doctor such sums as may be due to him upon receipt of an itemized statement for services rendered to me by the Doctor. I hereby authorize and direct my insurance carrier to pay all benefits, which may be due me according to my policy, directly to Daniels Chiropractic Office to be applied to my account.

Signed:**X**_____Date:_____

NAME: _____ DATE: ___ / ___ / 20____

PATIENT SYMPTOMS

On the drawing below, please indicate where you are experiencing pain by drawing the letter abbreviations on the diagrams that most accurately reflect the type of discomfort that you have been experiencing. Please feel free to draw arrows showing direction of radiating pain as well as write any notes in the margins.

Regarding your chief complaint, did you want to

____just get rid of the symptoms

____ get rid of the CAUSE of the symptoms (which could take longer).

____ take action to prevent future problems through wellness care.

Tingling – T Dull Pain - D
Sharp pain – P Burning – B Stiffness - S