New Patient Intake

PERSONAL INFORMATION

PLEASE PRINT
First Name: _____ Last Name:_____ Preferred Name:_____

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____/_____/_____ Age:_____ Sex: □ Male □ Female □ Unspecified SSN:_____/_____/_____

Primary Phone:_____ Email Address*:_____

**By providing my email address, I authorize my doctor to add me to the Chiro CLE newsletter as well as contact me via the email address provided.*

Contact Method: (check one) □ Call □ Text □ Email

Marital Status: (check one) □ Single □ Married □ Partnership □ Divorced □ Widowed

Spouse/Partner's Name:_____

Children?: □ Yes □ No How Many:_____

Race: □ White □ Black/African American □ Hispanic/Latino □ Asian □ Native American □ Other:_____

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ I choose not to specify

Occupation:_____ Employer:_____

Emergency Contact (Name, Relationship, Phone #):_____

Family Physician Name:_____City:_____

How were you referred to Chiro CLE?

□ Referred by:_____ □ Facebook □ Instagram □ Google Search □ Website
□ Community Event (specify which one):_____ □ Other:_____

Have you seen a chiropractor in the past? □ Yes □ No

INSURANCE OR PRIVATE PAY INFORMATION

Please provide insurance card(s) to the front desk.

Type of Insurance: □ Private Insurance □ Medicare □ Other:_____

Primary Insurance Carrier:_____

Member ID:_____ Group #:_____ Claim # (if applicable):_____

Name of Policy Holder:_____ Relationship to Patient:_____

Policy Holder's Birthdate:____/___/____ Policy Holder's SSN: ____/___/_____ Employer:_____

Is the patient covered by another insurance? □ Yes □ No

Secondary Insurance Carrier:_____ Member ID:_____ Group #:_____

ASSIGNMENT/AUTHORIZATION/RELEASE:

I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to *Chiro CLE*, all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that "co-pays" are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

□ **Private Pay/Cash:** By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered. Name of person responsible for this account:_____

Patient or Legal Guardian Signature (if minor):_____Date:_____

REASON FOR VISIT

What is the main reason for your visit today? (if more than one complaint, answer Q's twice, indicating which answer is for which area)

_____

_____

_____

What caused this complaint?_____

When did this complaint begin?_____

Have you had this or a similar complaint in the past? □ Yes □ No If "Yes," when? _____

What does your complaint(s) feel like? Circle all that apply: *Sharp / Dull / Sore / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness / Other:*_____

On the scale below, please circle the severity of your main complaint right now:

No pain Moderate pain Worst pain possible

|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|
0 1 2 3 4 5 6 7 8 9 10

What area(s) does the pain radiate, shoot, or travel to (if applicable)?_____

What aggravates this complaint? Circle all that apply: Sitting / Standing / Walking / Getting up from seat / Walking stairs / Inactivity / Sleeping / Physical Activity / Exercise / Movement / Bending forward / Bending backward / Twisting / Reaching / Lifting / Desk work / Sneezing / Coughing / Everything / Unknown / Other:_____

What relieves this complaint? Circle all that apply: Sitting / Standing / Walking / Resting / Exercise / Movement / Stretching / Massage / Chiropractic / Heat / Ice / Laying down / Medication / Nothing / Unknown / Other:_____

How often do you experience your symptoms? □ 25% of the day □ 50% of the day □ 75% of the day □ 100% of the day

What time of day do you experience your symptoms?: □ Morning □ Afternoon □ Evening □ While sleeping □ During activities □ After activities □ Symptoms are constant and do not change □ Symptoms come and go randomly □ Other:_____

With time, are your symptoms: □ Improving □ Worsening □ Not changing

Have you seen other doctors for this complaint? □ Yes □ No If "Yes", please provide the following information:

Doctor's name:_____ Date consulted:_____
Diagnosis:_____

Have you had an X-ray, CT scan, Diagnostic Ultrasound or MRI <u>for your current complaint(s)</u>? □ Yes □ No
<u>If "Yes", what imaging did you have, and when?)</u>_____

Is this condition interfering with your: (Circle all that apply) Sleep / Getting in or out of bed or chair / Personal care / Travel / Work / Recreation / Lifting / Walking / Standing / Daily Routine / Social Activities / Exercise / Other:_____

How much does your complaint interfere with your daily activities? □ Not at all □ A little bit □Moderately □ Quite a bit □ Extremely

HEALTH HISTORY

Please mark **ALL** the health conditions below that apply to **you** currently or in the past:

□ Osteoarthritis/Degenerative Joint Disease
□ Asthma
□ Diabetes, □ Type 1 □ Type 2
□ Anemia
□ Cancer/Tumor
- ➔ Type:_____

□ Rheumatoid Arthritis
□ Depression
□ Anxiety
□ Disc herniation
□ High blood pressure/Hypertension
□ Heart Disease/Stroke
□ High cholesterol
□ Whiplash injury
- ➔ Date of injury: _____

□ Headaches/Migraines
□ Joint pain
- ➔ Circle location(s): □ Shoulder □ Elbow □ Wrist □ Hip □ Knee □ Ankle □ Other: _____

□ Osteoporosis/Osteopenia
□ Epilepsy/Seizures
□ Hypothyroidism □ Hyperthyroidism
□ Fibromyalgia/Chronic fatigue
□ Genetic disorders
□ Car accidents (date, PI case, doctor consulted, treatment):_____
□ Please list any other medical conditions: _____

PAST INJURIES: (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date):

_____
_____

SURGERIES and/or HOSPITALIZATIONS (List and Date):

_____
_____

List current prescription medications including frequency and dosage, if known. If “NONE”, check here □

Name of prescription medication	*Dosage/Start date*	4.	
1.		5.	
2.		6.	
3.		7.	

List current vitamins and/or supplements you are currently taking, including frequency and dosage, if known.

_____

_____

_____

List any known allergies and your reaction. If “NO” known allergies, check here □

_____

_____

WOMEN ONLY:

Currently Pregnant? □ Yes □ No □ Unsure **Menopause?** □ Yes □ No

Have you had a C-Section? □ Yes □ No If “Yes”, how many? _____

FAMILY HISTORY

Please mark ALL conditions that run in your family and indicate his/her relationship to you (Father, Mother, Sister, Brother):

□ Cancer Relationship to you:

➔ Type: _____ _____

□ Anemia _____

□ Diabetes _____

➔ □ Type 1 □ Type 2

□ Heart disease/Stroke _____

□ High blood pressure _____

□ Genetic disorders _____

□ Rheumatoid arthritis _____

□ Other (List) _____

SOCIAL HISTORY

Height: Weight:

Do you currently exercise? □ Yes □ No

- ➔ If “Yes”, how many times per week? _____
- ➔ Intensity? □ Light □ Moderate □ Strenuous
- ➔ What type of exercise? _____

Do you currently smoke tobacco of any kind? □ Yes □ Former smoker □ Never smoked

- ➔ If “Yes,” how often do you smoke? □ Every day smoker □ Occasional smoker
- ➔ Circle your level of interest in quitting smoking? 10 = extremely interested 0 = no interest

|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|
0 1 2 3 4 5 6 7 8 9 10

Do you drink alcohol? □ Yes □ No

- ➔ If “Yes,” how many drinks per week? _____

Do you drink caffeine? □ Yes □ No

- ➔ If “Yes,” how many drinks per day? _____ What type? □ Coffee □ Tea □ Pop □ Energy drinks

Do you take pain killers? □ Yes □ No

- ➔ If “Yes,” how often? □ Daily □ Weekly □ Monthly □ Rarely
- ➔ What type? □ Aspirin □ Ibuprofen □ Tylenol □ Other: _____

What is your current stress level? □ Mild □ Moderate □ High

What do your work duties include? □ Sitting □ Standing □ Light labor □ Heavy labor □ Walking □ Other: _____

What are your other hobbies? _____

Please describe your overall health right now: □ Excellent □ Very good □ Good □ Fair □ Poor

What are your top 3 goals in coming to Chiro CLE?

1. _____
2. _____
3. _____

Chiro CLE

NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which by law, or as dictated by - our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice please sign the bottom of this page and return to our front desk receptionist.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care
2. Inadvertent disclosures - an open treating area means open discussion… If you need to speak privately to the doctor please let our staff know so we can place you in a private consultation room
3. For payment purposes - to obtain payment from any insurance company or other available collateral source, OR
4. To obtain a recent address on you in the event you move and do not leave a forwarding address, we may use your 'emergency contact information' in whatever way necessary to locate you and collect any outstanding sums you may owe the practice/doctor
5. For personal injury cases and workers compensation purposes - to process a claim or aid in investigation
6. Emergency- in the event of a medical emergency we may notify a family member
7. For public health and safety - in order to prevent or to lessen a serious or imminent threat to the health or safety of a person or general public
8. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person
9. For military, national security, prisoner and government benefits purposes
10. Deceased persons – discussion with coroners and medical examiners in the event of a patient's death
11. Telephone calls, emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events
12. Change of ownership - in the event this practice is sold the new owners would have access to your PHI

Note: At any time, this office may update the list of ways your PHI may be used and all updates are deemed retroactive.

YOUR RIGHTS:

1. To receive an accounting statement of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request restrictions on certain uses and disclosures and with whom we release information
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information, however like restrictions we are not required to agree to them

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information please call Dr. Sara Rimes at (440) 497-0780. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:
DHHS, Office of Civil Rights 200 Independence Ave. SW Room 509F HHH Building Washington DC 20201

I **understand that this** office reserves the right to amend this notice of privacy practice at a time in the future and will make the new provisions effective for all information that it maintains past and present. My signature below is an acknowledgement that I have received a copy of *Chiro CLE*'s Patient Privacy Notice and I understand my rights as well as the practices to protect my health information. With my signature, I am conveying my understanding to the doctor. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient or Legal Guardian Name (Print):_____

Patient or Legal Guardian Signature:_____ Date:_____

CHIRO CLE

OFFICE POLICY AND INFORMED CONSENT

The best doctor/patient relationship is when there is complete understanding of the treatment and financial responsibilities between the doctor, staff and the patient. Our primary concern is being able to schedule you as required without creating a problem for you in keeping your account up to date. This will allow you to obtain the healthcare you need and handle your fees in a convenient manner.

Insurance

We shall assist in all possible ways to help you process and obtain all of the benefits for which you are eligible. We must emphasize as Chiropractic Care Providers, our relationship is with you, not your insurance company. While filing insurance claims is a courtesy that we extend to our patients, the financial obligation is yours and you are ultimately responsible for all charges. For your own information, please check with your insurance company as to the policy benefits to which you are eligible. We will advise you to pay any amount due for the “deductible”, “co-pay” and/or any other “non-covered” charges.

Medicare

Our office will submit all Medicare services to Medicare. Patients who have Medicare benefits are required to pay their portion as services are rendered. Once the annual deductible has been satisfied, the patient will be responsible for the portion not covered by Medicare.

Personal Payment

Patients who do not have Chiropractic benefits included in their insurance coverage are expected to make payments at each visit. For your convenience we accept cash, personal checks, and most major credit cards. We will be happy to discuss your financial charges. This will allow you to obtain the healthcare you need and handle your fees in a convenient manner.

Payment Agreement

I have read and understand the Office Policy as it pertains to my financial responsibility. I understand that I am responsible for any balance due at the time that services are rendered. I am aware that if my account is past due by 30 days there will be a 1.5% finance charge added to my balance monthly. Should collection of services be required, fees for those services will be added to my balance and will be my responsibility. I also understand that I am responsible for all court costs and attorney fees should legal action be required. I agree that if I discontinue my care for any reason: 1) Any time of service or other house discounts will be voided. 2) I will pay the balance in full at the time.

Informed Consent

I hereby request and consent to chiropractic manipulation and other procedures including various modes of physical therapy, modalities, or tests Dr. Sara Rimes or her staff who now or in the future will treat me while employed by this office. I have had an opportunity to discuss with the doctor and/or with office personnel the nature and purpose of treatment indicated. I understand that results are not guaranteed and I 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 fractures, disc injuries, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time is in my best interest. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by this office and/or employed staff.

Patient or Legal Guardian Name (Print):_____

Patient or Legal Guardian Signature:_____ Date:_____

CHIRO CLE
Cancellation & No-Show Policies

Enforcing a cancellation/no-show policy is one of the more difficult things for *Chiro CLE* to do. However, it is necessary to ensure the high level of care we strive to provide for all patients. We reserve your appointment time specifically for you. If you do not show up for your appointment or cancel at the last minute, it becomes both a lost opportunity for another patient to receive care and a financial loss for the practice. We understand that unanticipated events can happen in life, but we aim to be fair to all patients and maintain a reputable practice.

CANCELLATION & NO-SHOW POLICY

• *Chiro CLE* requires a 24 hour grace period for canceling any appointment. This time allows us to schedule another patient to be seen during your scheduled time. If you cancel outside of this 24 hour window, you will be charged a $40 cancellation fee.

• If you forget your appointment or consciously choose to forgo your scheduled appointment time, you will be charged a $40 no-show fee.

LATE ARRIVALS

• If you are running late for an appointment, please call the office to let the doctor know. Depending on how late you arrive, your appointment may be shortened and end at the originally scheduled time in order to accommodate other patients whose appointments follow yours.

We thank you for your support of *Chiro CLE* and appreciate your cooperation and understanding!

Patient or Legal Guardian Name (Print):_____

Patient or Legal Guardian Signature:_____ Date:_____

CHIRO CLE
Waiver of Financial Liability

Dr. Sara Rimes of *Chiro CLE* has advised me that my insurance company does not reimburse the treatment I am having and/or it might not be considered medically necessary. I have advised Dr. Rimes to proceed with the services, and I will assume full responsibility for the payment, or portion not to be covered by my insurance.

I authorized direct payment to *Chiro CLE* and Dr. Sara Rimes. I am aware that I am responsible for any co-payments, co-insurance and deductibles for services that are covered by my insurance carrier.

Treatments:
Dry Needling
Cupping
Kinesiology Taping
Electrical Stimulation

Patient or Legal Guardian Name (Print):_____

Patient or Legal Guardian Signature:_____ Date:_____