



New Patient Intake Form

PATIENT DETAILS	Today's Date		How did you hear about us?		Nickname		
	Last Name		First	MI	Sex · Male · Female	Birth Date	Age
	Address		Apt#	City	State	Zip	
	Cell Phone #		Secondary Phone #		Social Security #		
	Appt Reminder Preference · Text · Email · None		Cell Phone Provider		Personal Email		
	Married Status · Single · Married · Divorce			Parent Name (for minor patients only)			
	Emergency Contact		Relationship		Phone #		
	Employer Name				Job Title		

HEALTH HISTORY	What treatment have you already received for your condition? · Medications · Surgery · Physical Therapy · Chiropractic Services · None · Other _____					
	Have you ever had any imaging procedures for your current condition? · X-rays · CT Scan · MRI · None · Other _____					
	Place a mark on "yes" or "no" to indicate if you have had any of the following:					
	Alcoholism	·Yes ·No	Goiter	·Yes ·No	Pinched Nerve	·Yes ·No
	Allergy Shots	·Yes ·No	Gonorrhea	·Yes ·No	Pneumonia	·Yes ·No
	Anemia	·Yes ·No	Gout	·Yes ·No	Polio	·Yes ·No
	Anorexia	·Yes ·No	Heart Disease	·Yes ·No	Prostate Problem	·Yes ·No
	Appendicitis	·Yes ·No	Hepatitis	·Yes ·No	Prosthesis	·Yes ·No
	Arthritis	·Yes ·No	Hernia	·Yes ·No	Psychiatric Care	·Yes ·No
	Asthma	·Yes ·No	Herniated Disk	·Yes ·No	Rheumatoid Arthritis	·Yes ·No
Bleeding Disorders	·Yes ·No	Herpes	·Yes ·No	Rheumatic Fever	·Yes ·No	
Breast Lump	·Yes ·No	High Blood Pressure	·Yes ·No	Scarlet Fever	·Yes ·No	
Bronchitis	·Yes ·No	High Cholesterol	·Yes ·No	Stroke	·Yes ·No	
Bulimia	·Yes ·No	Kidney Disease	·Yes ·No	Thyroid Problems	·Yes ·No	
Cancer	·Yes ·No	Liver Disease	·Yes ·No	Tonsillitis	·Yes ·No	
Cataracts	·Yes ·No	Measles	·Yes ·No	Tuberculosis	·Yes ·No	
Chemical Dependency	·Yes ·No	Migraine Headaches	·Yes ·No	Tumors, Growths	·Yes ·No	
Chicken Pox	·Yes ·No	Miscarriage	·Yes ·No	Typhoid Fever	·Yes ·No	
Diabetes	·Yes ·No	Mononucleosis	·Yes ·No	Ulcers	·Yes ·No	
Emphysema	·Yes ·No	Multiple Sclerosis	·Yes ·No	Vaginal Infections	·Yes ·No	
Epilepsy	·Yes ·No	Mumps	·Yes ·No	Whooping Cough	·Yes ·No	
Fractures	·Yes ·No	Osteoporosis	·Yes ·No	AIDS/HIV	·Yes ·No	
Glaucoma	·Yes ·No	Pacemaker	·Yes ·No	Other:		
		Parkinson's Disease	·Yes ·No			

Signature: _____

Date: _____



Name: _____ Date of Birth ___/___/___ MRN# _____

Where are your primary complaints? (Check all that apply)

<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Elbow Pain	<input type="checkbox"/> Lower Back Pain	<input type="checkbox"/> Ankle Pain
<input type="checkbox"/> Headaches	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/> Hip Pain	<input type="checkbox"/> Foot Pain
<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> Hand Pain	<input type="checkbox"/> Leg Pain	<input type="checkbox"/> Heel Pain
<input type="checkbox"/> Arm Pain	<input type="checkbox"/> Middle Back Pain	<input type="checkbox"/> Knee Pain	<input type="checkbox"/> Other _____

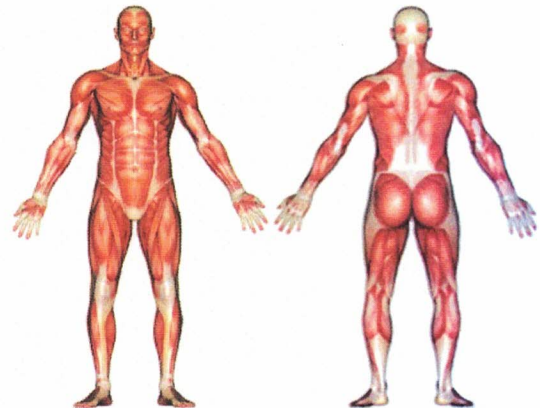
What type of pain do you experience? (Check all that apply)

<input type="checkbox"/> Sharp	<input type="checkbox"/> Shooting	<input type="checkbox"/> Swelling	<input type="checkbox"/> Other _____
<input type="checkbox"/> Aching	<input type="checkbox"/> Stiffness	<input type="checkbox"/> Numbness	
<input type="checkbox"/> Cramping	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Tingling	
<input type="checkbox"/> Dull	<input type="checkbox"/> Burning	<input type="checkbox"/> Spasms	

Are you able to make you own financial and medical decisions regarding the recommended treatment? Yes No

If no, who must accompany you for final decision making?

FOR OFFICE USE ONLY!





Patient Name: _____

Family Health History

Many health problems are hereditary in nature and may be handed down generation from generation. Please review the below-listed diseases and conditions and indicate those that are recurrent health problems of a family member. Leave blank those that do not apply. If you require more space, use the reverse side of this form. Circle your answers if your relative lives around this locality, as some heredity conditions are affected by similar environments.

Condition	FATHER	MOTHER	SPOUSE	BROTHER(S)		SISTER(S)		CHILDREN		
	Age ____	Age ____	Age ____	Age ____	Age ____	Age ____	Age ____	Age ____	Age ____	Age ____
Arthritis										
Asthma – Hay Fever										
Back Trouble										
Bursitis										
Cancer										
Constipation										
Diabetes										
Disc Problem										
Emphysema										
Epilepsy										
Headaches										
Heart Trouble										
High Blood Pressure										
Insomnia										
Kidney Trouble										
Liver Trouble										
Migraine										
Nervousness										
Neuritis										
Pinched Nerve										
Scoliosis										
Sinus Trouble										
Stomach Trouble										
Other:										

If any of the above family members are deceased, please list their age at death and cause:



OFFICE FINANCIAL POLICY

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.
2. HEALTHY4LIFE, Inc. may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.
3. All payments made to the HEALTHY4LIFE, Inc. for insufficient funds will be charged a \$25.00 processing fee regardless of amount. Thereafter acceptable payment will be cash or credit card only.
4. If you have insurance, HEALTHY4LIFE, Inc. will gladly accept assignment with the following exceptions and regulations, provided we have prior certification from your insurance company.
5. HEALTHY4LIFE, Inc. accepts assignment for the initial treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment per visit.
6. HEALTHY4LIFE, Inc. accepts assignment as a courtesy to you; you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.
7. Whenever you receive any worksheets from your insurance company or explanation of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine whether proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue you an overpayment check-it will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account if any balance is due.
8. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.

9. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.
10. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payment in full expected immediately; regardless of any claims submitted.
11. If you have questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the Doctor.
12. **Any accounts that become overdue 90 Days or more will be referred to a third party collection agency.**

I have read and understand this Financial Office Policy and agree to abide by all terms.

Patient's Signature

Date

I understand that I am not personally responsible for the fees associated with the first visit but due to contractual obligations, I understand and agree that all fees associated with my first visit to this office, including but not limited to, exam, all necessary x-rays, and test adjustment will be billed to my insurance company.

Patient's Signature

Date



Informed Consent to Chiropractic Care

You are the decision maker for your health care. Part of our role is to provide you with the information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the

care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examination or tests concluded will be carefully performed but may be uncomfortable. Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving healthcare or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic care can involve manually and/or mechanically adjusting the cervical spine, it had been reported that chiropractic care may be a risk for developing this type of stroke. **The association with stroke is exceedingly rare and is estimated to be related in one in one million- one in two million cervical adjustments.**

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other options about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had the opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future conditions for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian : _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____



CONSENT FOR TREATMENT AND AUTHORIZATION TO PERFORM X-RAYS

I authorize HEALTHY4LIFE, INC to perform a radiographic examination if the Doctor deems necessary to diagnose and to administer whatever examination or treatment is deemed necessary to treat my present problem (or illness).

To the best of my knowledge I am NOT pregnant, and the above-named clinic has my permission to x-ray me for diagnostic interpretation.

Patient's Signature

Date



HIPAA PRIVACY POLICY CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to/for:

- Carry out treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (i.e. my insurance company)
- The day to day healthcare operation of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient's Signature

Date



AUTHORIZATION, ASSIGNMENT & RELEASE FORM

In consideration of your undertaking of care from HEALTHY4LIFE, Inc., I agree to the following:

1. HEALTHY4LIFE and/or Dr. Bryan S. Aldrich is authorized to release any information deemed appropriate and necessary concerning my physical condition to any insurance company or adjuster to process any claim for reimbursement of charges I incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney (personal injury cases) , from the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you, based in whole or in part upon the charges made for your services.
3. In the event any insurance company is obligated to make payment to me or to you for the charges made for your services, refuse to make such payment upon demand by you; I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute and take action in my name as you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance companies' proceeds, whether it is all or part of what is due, I personally owe and agree to pay you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in the State of South Carolina.
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization and Assignment will be in continual effort until revoked by both parties.

Patient's Signature

Date



New Patient Routing Form

Today's Date:

Front Desk

Patient Name:

DOB:

MRN#:

Referral Prog/Event:

Ref. person:

Insurance Type:

Case Type: Comm MC C PI

** If insurance card is not with them fill out No Insurance Card Form**

Subscriber (if different than patient) DOB:

Car Accident Case: Yes / No

Using a Lawyer: Yes / No

Paperwork signed and completed: Yes / No

ALL demographic information updated in ChiroTouch: Yes / No

Day 2 Date:

Patient Educator

Q

NQ

Ruin:

Billing

Insurance Verification Completed: Yes / No

UHC Optum Completed: Yes / No / NA _____ Initial

Financials Completed: Yes / No

Input Insurance into Chart: Yes / No / NA

Bryan S. Aldrich, B.A., D.C.

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