PhysioDelta
Chiropractic

Patient Intake Forms

PATIENT INFORMATION

Name: _____ **Date:** _____

Date of Birth: _____ **Male:** _____ **Female:** _____

Street Address: _____ **City:** _____

State: _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

Email Address: _____

Occupation: _____ **Employer:** _____

Emergency Contact: _____ **Relationship:** _____

Emergency Contact Number: _____

PERSONAL HEALTH INSURANCE

Health Insurance Carrier: _____

Policy Number: _____ **Group Number:** _____

Policy Holder: _____ **Policy Holder DOB:** _____

PAST MEDICAL HISTORY

Medical Conditions: _____

_____

_____

Allergies: _____

Medications: _____

Surgeries: *Year:* _____ *Procedure:* _____

Year: _____ *Procedure:* _____

Year: _____ *Procedure:* _____

Major Hospitalizations: _____

Significant Prior Injuries: _____

_____

GENERAL MEDICAL HISTORY

Place an "X" next to any of the following items that apply to you.

Dizziness		Lightheadedness	
Double Vision		Numbness	
Difficulty Speaking		Nausea	
Difficulty Swallowing		Loss of Balance	

Bowel or Bladder Loss		Lower Extremity Weakness	
Groin or Genital Numbness		Sexual Dysfunction	

Unexplained Weight Loss or Gain		History of Cancer	
Fever		History of Osteoporosis	
Chills		History of Corticosteroids	
Vomiting		Chest Pains	
Persistent Cough		Abdominal Pains	
Night Sweats			
Pain at Night			

SOCIAL HISTORY

Are you currently pregnant? (women only) *Yes:* _____ *No:* _____

Do you drink alcohol? *Yes:* _____ If yes, how many drinks? _____ *No:* _____

Do you smoke tobacco? *Yes:* _____ If yes, how much? _____ *No:* _____

Do you use recreational drugs? *Yes:* _____ If yes, which drug(s)? _____ *No:* _____

Do you have a history of substance abuse or use of IV drugs? *Yes:* _____ *No:* _____

If yes, which drug(s)? _____

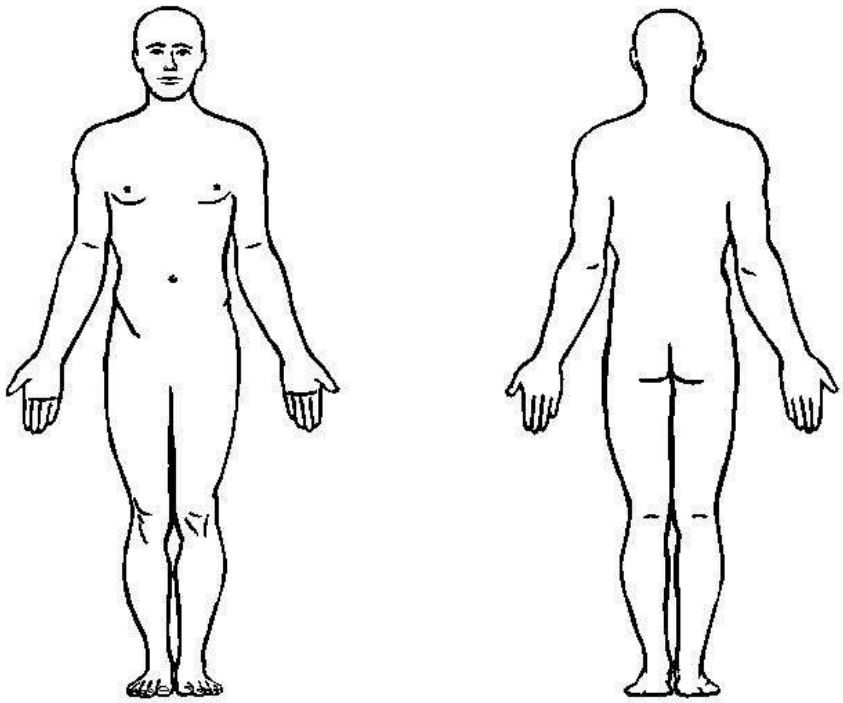
Do you exercise? *Yes:* _____ *No:* _____

If yes, how frequently? _____

If yes, what type of exercises? _____

HISTORY OF PRESENT COMPLAINT

Place an "X" over the area(s) of your current complaint.



Height: _____ Weight: _____

How long ago did your symptoms begin? _____

How did your symptoms begin? _____

Please describe your symptoms. (achy, dull, sore, sharp, etc.)

_____

_____

Have you treated at another healthcare facility for this complaint? *Yes:* _____ *No:* _____

If yes, where? _____

Circle the number below that corresponds to your pain level.
(0 = no pain 10 = severe pain)

0 1 2 3 4 5 6 7 8 9 10

Place an "X" on the line at about where you think your pain level is.

|----------|

No Pain *Severe Pain*

PERSONAL GOALS AND ACTIVITIES

Has your complaint compromised your daily function and/or activities? *Yes:* ____ *No:* ____

What daily activities have been compromised due to your current complaint?

_____

_____

_____

Are there any recreational, personal, or social activities that have been compromised that you wish to return to or do with less difficulty? If so, please explain below.

_____

_____

_____

What are you looking to get out of the care provided to you at PhysioDelta Chiropractic?

_____

_____

_____

How did you hear about us? _____

Patient Name (print)**:** _____

Patient Signature: _____

Doctor Signature: _____

INFORMED CONSENT

Informed Consent for Chiropractic Examination and Treatment

Introduction: This document is intended to inform you, the patient, about the nature and risks associated with chiropractic examination and treatment. Please read it carefully and feel free to ask any questions or seek clarification before proceeding with any chiropractic care.

Chiropractic Examination and Treatment: Chiropractic care involves the assessment, diagnosis, and treatment of neuromusculoskeletal conditions, particularly those related to the spine and extremities, through manual adjustments, myofascial release, therapeutic rehabilitation, and other therapeutic techniques. Chiropractors are trained professionals who use their hands or specialized instruments to apply precise interventions to the affected structures, aiming to improve discomfort, mobility, and overall function.

Risks and Benefits: Chiropractic examination and treatment carry certain risks, including but not limited to:

- Soreness or discomfort in treated areas
- Temporary headaches
- Increased pain or stiffness

However, chiropractic care also offers potential benefits, including:

- Relief from pain and discomfort
- Improved mobility and range of motion
- Enhanced overall function, well-being, and quality of life

Alternative Treatments: There may be alternative treatments available for your condition, including medical prescriptions, physical therapy, massages, acupuncture, and/or surgery. Your chiropractor will discuss these options with you and help you make an informed decision about your care.

Consent for Examination and Treatment: By signing below, you acknowledge that you have read and understood the information provided in this document. You voluntarily consent to undergo chiropractic examination and treatment, understanding the potential risks and benefits associated with it. You also agree to inform your chiropractor of any changes in your health status or any concerns that may arise during the course of treatment.

Patient's Name: _____

Patient's Signature: _____ Date: _____

Guardian or Witness Signature: _____ Relationship: _____

Chiropractor's Name: _____

Chiropractor's Signature: _____ Date: _____

I have discussed the contents of this form with the patient and addressed any questions or concerns they may have had.

PAYMENT POLICY

Payment Policy for PhysioDelta Chiropractic

Thank you for choosing PhysioDelta Chiropractic for your chiropractic care needs. To ensure clarity and transparency regarding our payment procedures, we have outlined our payment policy below:

1. Payment Responsibility:
    - Payment is due at the time a care plan is established and services are rendered, unless prior arrangements have been made with the examining clinician and/or management.
    - The examining clinician will establish and outline the prescribed management plan, cost of care, and plan frequency following the initial assessment.
    - We accept cash and credit/debit cards. Please inquire with the examining clinician regarding cost and payment.
2. Refund Policy:
    - We operate under a strict no-refund policy. Once a management plan is established, payments made are non-refundable, regardless of the outcome of treatment or any other circumstances.
    - This policy applies to all services rendered, including but not limited to consultations, examinations, treatments, and ancillary services.
3. Insurance Billing:
    - PhysioDelta Chiropractic is an out-of-network healthcare facility and does not accept insurance for payment etc. This ensures that patients are receiving the highest quality care with no external restrictions.
    - Upon request, a Superbill may be provided to the patient outlining the cost of care that can then be submitted to the patient's respective insurance carrier for reimbursement. Submissions of a Superbill will need to be handled by the patient exclusively. Please inquire with the examining clinician for any questions you may have.

By signing below, you acknowledge that you have read and understood the payment policy outlined above. You agree to comply with the terms and conditions set forth herein, including the no-refund policy.

Patient's Name: _____

Patient's Signature: _____ Date: _____

If you have any questions or concerns regarding our payment policy, please do not hesitate to contact our office. We appreciate your cooperation and understanding.

CANCELLATION POLICY

Cancellation Policy for PhysioDelta Chiropractic

At PhysioDelta Chiropractic, we strive to provide exceptional care and service to all of our patients. To ensure efficient scheduling and to accommodate the needs of all our patients, we have implemented the following cancellation policy:

1. Cancellation Notice:
    - We require a minimum of 24 hours' notice for appointment cancellations or rescheduling.
    - If you need to cancel or reschedule your appointment, please notify us at least 24 hours in advance to avoid any fees.
2. Cancellation Fee:
    - Failure to provide at least 24 hours' notice for appointment cancellations or rescheduling will result in a cancellation fee of $100.
    - This fee will be charged to the credit/debit card on file or will be due at your next appointment.
3. Exceptions:
    - We understand that emergencies and unforeseen circumstances may arise, and exceptions may be made on a case-by-case basis.
    - However, repeated instances of late cancellations or no-show appointments may result in additional fees or restrictions on scheduling future appointments.

By signing below, you acknowledge that you have read and understood the cancellation policy outlined above. You agree to comply with the terms and conditions set forth herein, including the cancellation fee.

Patient's Name: _____

Patient's Signature: _____ Date: _____

If you have any questions or need to cancel or reschedule your appointment, please contact our office as soon as possible. We appreciate your cooperation and understanding.

PHOTO AND VIDEO CONSENT

Photo and Video Consent

I, _____, hereby grant permission to PhysioDelta Chiropractic ("the Practice") to use my likeness in photographs and/or videos for the purpose of promoting the Practice's services and activities. This consent includes the use of my image on the Practice's website, social media platforms, promotional materials, and any other marketing channels deemed appropriate by the Practice.

I understand and agree to the following terms:

1. Use of Likeness:
    - I authorize the Practice to use photographs and/or videos in which I appear for promotional and marketing purposes related to the Practice.
    - I understand that my likeness may be used in various forms of media, including but not limited to print, digital, and social media platforms.
2. Confidentiality:
    - I acknowledge that the Practice will make reasonable efforts to protect my privacy and will not disclose any personal or sensitive information without my consent.
    - I understand that while the Practice will endeavor to remove my name or any identifying information from promotional materials, it may not always be possible to do so.
3. Release of Liability:
    - I release the Practice, its agents, employees, and representatives from any liability arising from the use of my likeness in promotional materials.
    - I understand that the Practice will not be held responsible for any unauthorized use of my likeness by third parties.
4. Revocation of Consent:
    - I understand that I have the right to revoke this consent at any time by notifying the Practice in writing. However, any promotional materials already produced or distributed by the Practice may continue to be used.

By signing below, I acknowledge that I have read and understood the terms of this consent form and agree to its provisions.

Patient's Name: _____

Patient's Signature: _____ Date: _____

If the patient is a minor:

Parent/Guardian's Name: _____

Parent/Guardian's Signature: _____ Date: _____

PRIVACY NOTICE

Patient Information and Privacy Notice

At PhysioDelta Chiropractic we understand the importance of protecting your personal health information (PHI), and we are dedicated to maintaining the highest standards of privacy and security in accordance with applicable laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA). If you have any questions or concerns regarding your PHI or transmission of PHI/medical records etc. please address them with your examining clinician.

Uses and Disclosures of PHI: We may use and disclose your PHI for treatment, payment, and healthcare operations purposes without obtaining your prior authorization. For example:

- **Treatment**: We may use and disclose your PHI to provide you with chiropractic care, including consultation with other healthcare providers involved in your treatment.
- **Payment**: We may use and disclose your PHI to bill and collect payment for the services we provide to you.
- **Healthcare Operations**: We may use and disclose your PHI for activities such as quality assessment, training, and improving our services.

Correspondence Consent: Our practice may send your health information, including medical records and other documentation via email, fax, or traditional mail, as necessary for the provision of your healthcare services. This information may be sent to you, other healthcare providers involved in your care, or insurance companies for purposes related to treatment, payment, or healthcare operations etc. By consenting to this policy, you accept the possible security risks that may be associated with each method of correspondence.

Authorization Requirement: For uses and disclosures of your PHI beyond those permitted without authorization, we will obtain your written authorization. You have the right to revoke any authorization you provide at any time, except to the extent that we have already taken action in reliance on that authorization.

Individual Rights: You have the following rights regarding your PHI:

- **Right to Access**: You have the right to inspect and obtain a copy of your PHI contained in your designated record set, with limited exceptions.
- **Right to Amend**: You have the right to request an amendment of your PHI if you believe it is inaccurate or incomplete.
- **Right to Restrict Use and Disclosure**: You have the right to request restrictions on certain uses and disclosures of your PHI.
- **Right to Accounting of Disclosures**: You have the right to receive an accounting of certain disclosures of your PHI.
- **Right to Request Confidential Communications**: You have the right to request that we communicate with you about your PHI in a certain way or at a certain location.

Notice of Privacy Practices: You have the right to obtain a paper copy of this notice upon request, even if you have agreed to receive this notice electronically.

Breach Notification: In the event of a breach of your unsecured PHI, we will notify you as required by law.

Changes to this Notice: We reserve the right to change the terms of this notice at any time. Any changes will be effective for PHI we already have about you as well as any information we receive in the future.

Patient's Name: _____

Patient's Signature: _____ Date: _____