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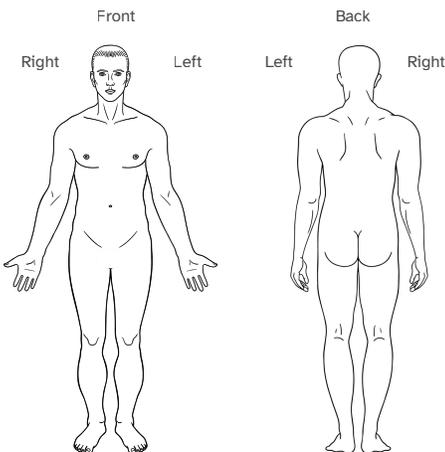
CHIROPRACTIC INTAKE FORM

Name _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Birth Date _____ Age _____ Height _____ Weight _____
 Phone _____ Email _____
 Marital Status Single Married Divorced Widowed How did you learn about us? _____
 Occupation _____ Employer / School _____ Phone _____
 Emergency Contact _____ Relationship _____ Phone _____

Patient Condition

Reason for Visit _____
 When did your symptoms appear? _____ Is this condition getting worse? Yes No Unsure
 Is it constant or does it come and go? _____
 Does it interfere with your Work Sleep Daily Routine Recreation
 Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down
 What treatment have you already received for your condition? Medication Surgery Phys. Therapy Chiropractic
 Is your condition due to an accident? No Auto Work Date of Accident _____

Please mark where you have pain or symptoms. Please check the symptoms. (Mark all appropriate)



- Sharp Stiffness Cramping
- Shooting Uncomfortable Dull
- Numbness Tenderness Tingling
- Stabbing Swelling Throbbing
- Aching Other _____

Out of 10, mark the severity of your symptoms.

0 1 2 3 4 5 6 7 8 9 10
 No Symptoms Intense Symptoms

Health and illness History

<input type="checkbox"/> Allergies	<input type="checkbox"/> Fracture	<input type="checkbox"/> TMJ	<input type="checkbox"/> Surgery
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Sciatica	<input type="checkbox"/> Blood Clot	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Migraine	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Surgery	<input type="checkbox"/> Cardiovascular
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Digestive Issue	<input type="checkbox"/> Urinary Issue	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Immune Issue	<input type="checkbox"/> Kidney Issue	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Depression	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Bladder Issue	<input type="checkbox"/> Thyroid Issue
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Menstrual Issues	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> High BP	<input type="checkbox"/> Heart Disorder	<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Pace Maker / Defibrillator
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Herniated Disk	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Tumors / Growths
<input type="checkbox"/> Asthma	<input type="checkbox"/> Auto Crash	<input type="checkbox"/> Psychiatric Care	

Are you currently pregnant? Yes No Other _____

Injuries / Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications you are currently taking _____
(Have a printed or online medication list? We can make a copy for you!)

OFFICE FINANCIAL POLICY AND PATIENT CONSENT

If you have Insurance: By signing this form you are agreeing that you understand that all deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed \$100 or care may be terminated. Our payment plans make care an affordable part of your family budget. We do not accept assignment for or file claims for secondary insurance carriers, but will be happy to provide you with a proper receipt for your use. Our fees are considered usual, customary, and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area. If your carrier has not paid a claim within 60 days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect payment in full. If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted. If your claim is for personal injury/auto, you understand that our office will accept a lien from your attorney and/or bill claims directly to your own auto insurance medpay benefit. We do not accept assignment from the responsible party's insurance. If you do not have any attorney or medpay coverage, you will be responsible for payment as service is rendered. X-RAYS: I understand that any x-rays performed in this office, remain the explicit property of this clinic. Maintenance/Wellness Care: When your schedule of visits is once per month or longer, you will not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered, or you may choose to be on our wellness payment plan.

Signature _____ Name _____ Date _____

Financial Policy/ Cash Patients: If you do not have insurance, all payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed \$100 at any time or care may be terminated. You further understand, that all billing fees and financial procedures as listed on this form, apply the same to you as those with insurance and you agree to such fully by signing below. Further, by signing below, I understand that if it is necessary for my account to be turned over to collections due to non-payment or late payment, that I will be responsible for all collection fees, attorney fees, and court costs associated with such collections. I also understand that if my account becomes delinquent, I will be charged billing fees of \$5 per statement, and interest at a rate of 1.75 percent per month on the unpaid balance.

Patient Consent: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physicians.

Release of Information: By signing this form, you are granting consent to Cleveland Non Surgical PC to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at 423-473-9700. You have the right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or healthcare operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Medicare and Medicaid Consent to Release Information: I certify that the information given by me in applying for payment under Title XVIII and/or Title XU if the Social Security Act is correct. I authorize any holder of medical or other information about me, to release the Social Security Administration or its intermediary carriers, any information needed for this or related to Medicare or Medicaid claim.

Verification of Non-Pregnancy (for female patients only): By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.
Date of last menstrual period: _____

HIPPA Consent: I give permission for the individuals listed below to obtain my protected health information, and unless otherwise specified, the individuals may schedule and cancel appointments on my behalf or on behalf of my minor child. If this consent is for my minor child, it is also permission for listed individuals to bring my minor child to his/her appointments and as such is consent for the doctor to treat my minor child in my absence. I understand anyone not listed on this form will be denied ANY information, including information about my appointment times.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient's Printed Name: _____ Date: _____

Patient's Signature: _____

INSURANCE INFO & CONSENT

Who is financially responsible for this account? _____

Primary Insurance

Insurance Company _____

Subscriber ID _____

Subscriber's Name _____

Subscriber's DOB _____

Subscriber's SS# _____

Relationship to Patient _____

Secondary Insurance

Insurance Company _____

Subscriber ID _____

Subscriber's Name _____

Subscriber's DOB _____

Subscriber's SS# _____

Relationship to Patient _____

Insurance Consent

I, _____, hereby authorize and instruct the following insurance carrier to send (mail) all paid monies for diagnostic testing, treatment, and/or medical supplies to the facility listed above whose tax ID is 76-0745855.

Insurance Carrier: _____

By Signing Below I agree to and authorize the following:

- Said Doctor to release any information pertinent to my case to the mentioned insurance carrier
- A photocopy of this authorization shall be considered as valid as the original
- Said Doctor to use my name in the "Signature on file" in future billings
- Insurance Company to make direct payment to the above doctor/facility listed on this form
- The use of this form on all my insurance submissions (billings)
- I understand that if it is necessary for my account to be turned over to collections due to non-payment or late payment, that I will be responsible for all collection fees, attorney fees, and court costs associated with such collections. I also understand that if my account becomes delinquent, I will be charged billing fees of \$5 per statement, and interest at a rate of 1.75 percent per month on the unpaid balance.

LIMITED POWER OF ATTORNEY FOR PAYMENT OF MEDICAL BILLS: I hereby, give limited Power of Attorney, for said Doctor/Clinic, to cash and deposit any sums paid by the above insurance carrier for only the specific injury indicated on this form.

Date: _____ **Patient Name (Please Print):** _____

Signature of Patient: _____

(Or responsible Adult if patient is minor child)

FOR OFFICE USE ONLY

Ind Deductible \$ _____ Met \$ _____

Family Deductible \$ _____ Met \$ _____

\$ _____ Co Pay / _____ % Co Ins

of Visits / Yr _____ Used _____

Max Out of Pocket \$ _____ Met \$ _____

Notes _____

Date _____
