

Dr Shutko CHIROPRACTIC NEW PATIENT INTAKE

Name: _____ Today's Date: _____

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

Home Telephone: () _____ Work: () _____ Cell: () _____

Email Address: _____ Male: ____ Female: ____

Social Security Number: _____ Birth Date: _____ Age: _____

Emergency Contact Name: _____ Phone Number: () _____

Employed? (Yes) (No) Employer: _____ Marital Status: (Single) (Married) (Other): _____

Ethnicity/Race : (Caucasian) (Asian) (African American) (Hispanic/Latino) (Other) : _____

Have you seen a Chiropractor before? (Yes) (No) If yes, when? _____

Whom may we thank for referring you to our office? _____

YOUR HEALTH HISTORY

Please check all symptoms you have ever had, even if they do not seem related to your current problems.

Headaches	Pins and Needles in legs	Fainting	Neck Stiffness
Pins and Needles in arms	Loss of smell	Back Pain	Loss of Balance
Dizziness	ringing in ears	ringing in ears	Nervousness
Numbness in fingers	Numbness in toes	Loss of taste	Stomach upset
Fatigue	Depression	Irritability	Tension
Sleeping problems	Neck Pain	Cold hands	Cold feet
Cold Sweats	Constipation	Fever	Hot flashes
Mood Swings	Lights bother eyes	Problem urinating	Heartburn
	Menstrual Pain	Menstrual irregularity	Seizures

Do you smoke? Yes/No. If yes: How many years/packs per day? _____

List any medications you are taking: _____
_____ N/A or None.

Do you have any medically-diagnosed conditions?: _____
_____ N/A or None.

Does anyone in your family have any medically-diagnosed conditions (If so, whom)?: _____
_____ N/A or None.

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk.
Please initial to indicate you have been made aware of its availability: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Dr. Nicole Shutko Chiropractic/ Health Choice

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Release of Information: Your Protected Health Information (PHI) will be used by this office and/or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the Privacy Practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information: You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent: You may revoke this consent to the use and disclosure of your PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I, _____ (print) acknowledge that I have reviewed the above information and I authorize this office to release information concerning my condition and treatment to my insurance company, attorney, insurance adjuster and/or other health care providers deemed necessary for treatment purposes, processing my claim, benefits and payment of services rendered to me as well as coordinated treatment. I do understand that if I choose to refuse release of this information, that my PHI will be used **within** the office for purposes of my care, to those individuals designated by the doctor.

Patient or Guardian Signature: _____ Date: _____

Informed Consent for Treatment

I hereby request and consent to the performance of chiropractic procedures, various forms of physio-therapy, physical examination, x-ray studies, and/or any clinical services that are deemed necessary in my case to be administered by the doctor and/or any support staff employed or contracted by this office or clinic. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as "rare" and include, but are not limited to, muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fracture, disc injury, stroke, dislocations and sprains. I understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also be used to alleviate other symptoms through a conservative approach with hopes to avoid more invasive procedures. I further understand that, as with all healthcare treatments, results are not guaranteed and there is no promise to cure. I hereby acknowledge that if I do not keep appointments as recommended to me by my treating doctor, he/she has the right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. I further understand that there are other treatment options available for my condition, and that I have the right to a second opinion should I have concerns as to the nature of my symptoms and/or treatment options. If during the course of my care my insurance company requires me to take an examination from any other doctor, I will notify this facility/physician immediately. I understand that failure to do so may jeopardize my case.

I, _____ (print) have read the above consent and I have had an opportunity to ask questions regarding its content. By signing below, I agree to the above-named procedures and intend this consent to cover my entire course of treatment for my present condition and for any future condition(s) for which I seek treatment with this office.

Patient or Guardian Signature: _____ Date: _____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature: _____ Date: _____

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Health Choice Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____

FEMALES ONLY: To the best of my knowledge, I BELIEVE I AM NOT PREGNANT at the time the x-rays are taken at Health Choice Chiropractic.

Signature: _____ Date: _____

FINANCIAL OFFICE POLICY

1. All patients are on a cash basis until their respective insurance coverage and deductible are verified by our staff.
2. The Doctor will give you an estimate of the fees for service before they are performed or rendered.
3. If the deductible has not been met, you will be on a cash basis until such time that the deductible has been met.
4. Any refunds will be processed within 7-14 business days.
5. Waiting for insurance payment is a courtesy and it may be withdrawn under certain circumstances.
6. As a patient, it is your responsibility to take care of the co-payment and any non-covered services on a weekly basis. This office may make payment arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings. If you feel you need some assistance from a family member or parent with making a decision about your care, it is advisable that you bring them with you when the Doctor talks with you about your care.
7. This office does not warrant or guarantee that your insurance will pay. Nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between an insurance carrier and a patient or insured.
8. Any services not covered or coverage reduction 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 you receive any correspondence or checks from your insurance company, you agree to bring these into our office so that we may determine if any action needs to be taken or if the check is an assignment to this office.
11. 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 payable in full immediately, regardless of any claims submitted.
12. If you change insurance companies or employers, you agree to provide this office with current information immediately.
13. This office accepts, MasterCard, Discover, Visa, Cash and Personal Checks.
14. Client understands that if they wish to stop care prior to utilizing all credits, clients account balance will be prorated based upon the full rate cash fee per visit.
15. Clients participating in any corrective care plan or lifestyle care plan who decide to terminate before their care has been completed understand that a balance/credit check will be assessed to their account and any remaining balance will be withdrawn at or before time of termination.

I have read and understand the Financial Office Policy and agree to abide by these terms.

Patient Signature

Date