Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name: _____ **Date:** _____ (dd/mm/yr)

Insurance: _____

Date of Birth: _____ ☐ male ☐ female

Address: _____

_____

_____

Marital status

S	M	W	D	SEP

Phone #: home: _____ **work:** _____

E-mail address: _____

Occupation: _____ **Employer:** _____

Check ☑ and indicate the age when you had any of the following:

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful deification
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Women only
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual flow
☐ Reg. ☐ Irreg. ☐ Pain / cramps

Days of flow: ____ Length of cycle: ____

Date - 1st day last period: _____

Are you pregnant? ☐ yes, ☐ no

If yes, how many months? ____

How many children do you have? ____

Birth control method: _____

Date of last PAP test: _____

☐ normal, ☐ abnormal

Date of last mammogram: _____

☐ normal, ☐ abnormal

Check any of the conditions you have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Please list any medication you are currently taking and why:

_____

_____

_____

_____

Patient Intake Form (side 2)

Give a brief detailed description of the problem you are currently experiencing: _____

_____

_____

_____

_____

How long have you had this condition? _____ Is it getting worse? □ yes, □ no _____

Does it bother you (check appropriate box): □ work, □ sleep, □ other: _____

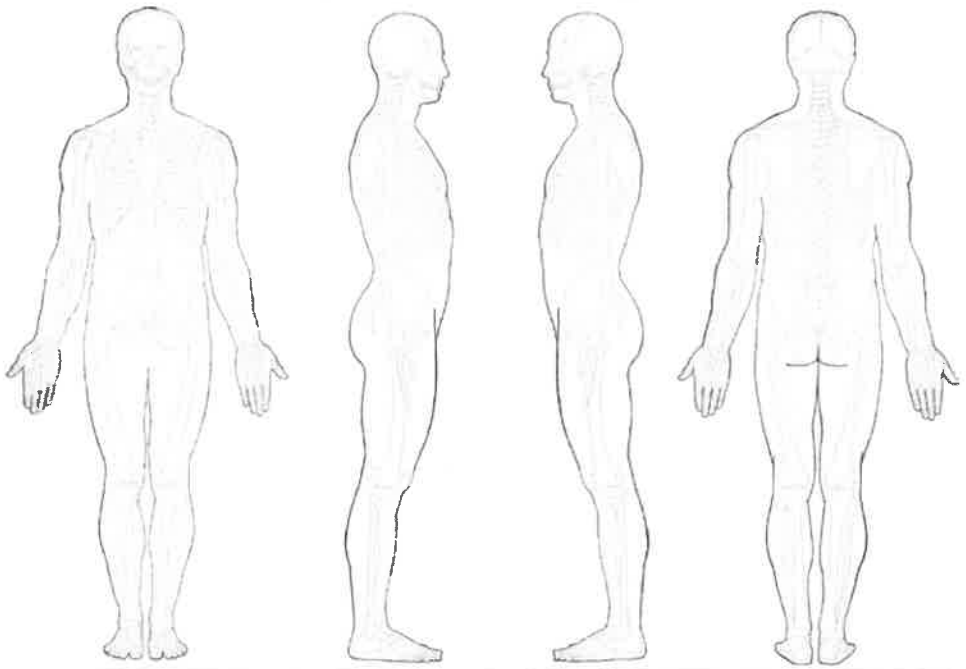
What seemed to be the initial cause: _____

Please mark you area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:

Worst Possible Pain

No Pain



Past health history

Have you...	Yes	No	If yes, explain briefly
... been hospitalized in the last 5 year?	□	□	_____
... had any mental disorders?	□	□	_____
... had any broken bones?	□	□	_____
... had any strains or sprains?	□	□	_____
... ever used orthotics?	□	□	_____
Do you take minerals, herbs or vitamins?	□	□	_____

How is most of your day spent? □ standing, □ sitting, □ other: _____

How old is your mattress? _____

When was your last physical exam? _____

Habits	none	light	mod.	heavy
Alcohol	□	□	□	□
Coffee	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□
Exercise	□	□	□	□
Sleep	□	□	□	□
Soft drinks	□	□	□	□
Salty foods	□	□	□	□
Water	□	□	□	□
Sugar	□	□	□	□

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

□ Alcoholism	□ Cancer	□ High blood pressure
□ Anemia	□ Diabetes	□ High cholesterol
□ Arteriosclerosis	□ Emphysema	□ Multiple sclerosis
□ Arthritis	□ Epilepsy	□ Osteoporosis
□ Asthma	□ Glaucoma	□ Stroke
□ Bleed easily	□ Heart disease	□ Thyroid disease

Do you have any other health issues or concerns that our staff should be made aware of? _____

_____

New Mexico Chiropractic Center (NMCC)
Informed Consent

To the patient: Please read this entire document prior to signing. It is important that you understand the information contained in this consent. Please ask questions before you sign if there is anything that is unclear to you. Thank you.

Analysis/Examination/Treatment:
I understand that I am consenting to a diagnostic and/or chiropractic adjustment and associated therapies. The examination may included but not limited to vital signs, neurological and orthopedic testing, palpation/ touch and radiographic images. The recommended treatment may include chiropractic spinal and extremity joint manipulations, trigger point acupressure, massage therapy, ice or heat therapy, electrical muscle stimulation, intersegment traction, manual traction and professional advice. The primary treatment employed is manipulative therapy in which I might feel movement and/or hear an audible 'pop'. I understand, as with all health care approaches, results are not guaranteed and there is no promise to cure.

Material risks inherent in the chiropractic adjustment and/or therapy:
I understand that there are certain risks to the procedures especially if I have any predisposing conditions. These complications include but are not limited to muscle soreness, muscle spasm, joint pain and stiffness, inflammation, headache, back pain, or bruising. More serious injuries can occur, such as cardiovascular complications like stroke, fracture or disc complications. While many of the risks are rare, I understand that they are inherent in physical medicine. I understand that the doctors at NMCC will make every reasonable effort during the examination to screen for complications or contraindications to care; however, if I have a condition that would otherwise not come to her attention, it is my responsibility to inform my doctor.

The availability and nature of other treatment options:
Rest, self-administered over the counter medications, medical care and prescription medications, Oriental medicine and acupuncture, Physical Therapy, bracing, injections, hospitalization or surgery. You have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit. If you choose one of the options above, you should be aware that there are risks and benefits associated with these options and you should discuss those with your primary care provider.

DO NOT SIGN THIS DOCUMENT UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.
I have read or have had read to me the above explanation of the chiropractic adjustment and related treatments. I recognize that informed consent is a dynamic process that fully rests on open and honest communication by all parties and can be changed at any time. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended by NMCC. Having been informed of the risks, I hereby give my consent to the recommended treatment.

Patient's name (Printed): _____

Patient's Signature: _____ Date: _____

Signature of Parent or Guardian _____ Date: _____

Witness: _____ Date: _____

NMCC - Patient Financial Responsibility Disclosure Statement

Your signature below forms a binding agreement between New Mexico Chiropractic Center and the patient who is receiving services. Your clear understanding of our financial policy is important to our professional relationship.

Welcome to our office! We are pleased you have chosen Chiropractic for your health care needs. Your health is your greatest asset, and, therefore one of the best things you can invest in financially.

Insurance

Patients with private health insurance policies for which the doctor is a contracted provider are responsible for deductibles, co-payments, co-insurance and non-covered services. All services rendered during office visits must be paid for at that time. Many private health insurance policies have visit limitations, maximum daily payout limitations, and/or calendar or contract year dollar amount limitations. If, at any time during the course of treatment, all insurance benefits have been exhausted, the patient will be treated on a cash basis.

All payments are expected in full at time of service.

Personal Injury/ Motor Vehicle Accident

Please inform us if there is a lawyer handling your case, as we require a Letter of Protection (LOP). Obtaining legal representation does not negate the patient's responsibility of payment in any way. If for any reason, the case is dropped or does not result in settlement, ***you are responsible for payment of services rendered.***

Self-pay

Patients with no insurance coverage are expected to *pay in full at the time of service.*

Missed Appointments/ Cancellation fees

Missed appointments or cancellations with less than 24 hour notice will be charged a $25.00 fee*.

If you have questions regarding prices, payment options or costs please feel free to ask the staff at New Mexico Chiropractic Center. We strive to make care affordable and convenient for you and your family.

I understand and will abide by the above policies,

Patient's name (print): _____

Patient's signature: _____

Date: _____

*exception at the doctor's discretion.

New Mexico Chiropractic Center

ABOUT MEDICARE CHIROPRACTIC COVERAGE

Your Medicare coverage of chiropractic care is limited. They will only pay for the chiropractic adjustment (manipulative treatment) when it meets Medicare's rules. There are three categories of Medicare services: 1) non-covered 2) always-covered, and 3) perhaps-covered.

NON-COVERED SERVICES

According to existing Medicare law, most of the available services in our office are NON-COVERED. Hopefully, the U.S. Congress will change that someday and treat Doctors of Chiropractic like all other doctors. Until then, here is a summary:

Examples of Non-Covered Services

All Services Other than Chiropractic Adjustments:

- Office Visits - to evaluate and manage, re-evaluate, advise, or counsel.
- Physiotherapy - such as massage, traction, electrical stimulation, neuromuscular re-education, etc.
- X-rays, Laboratory, Supplies, Vitamins, etc.

Various Chiropractic Adjustments:

- Non-spinal manipulation to the shoulder, arm, leg, etc.
- Maintenance Care - you are stable and not making any more improvement.
- Wellness Care - to promote better health.

Non-covered items will appear on your insurance claim form. They will show as a Medicare Non-covered service like this: "72010–GY". The "72010" code is for an x-ray. The "-GY" means that it is not-covered, allowing your service to go through the Medicare system. After denial by Medicare, it can then go on to your other insurance. If you have Medigap insurance (also known as Medicare Secondary or Supplemental insurance) they will pay according to the terms of your contract.

ALWAYS-COVERED SERVICES

A typical example of a Medicare COVERED service is when you are injured or you are in much pain due to a bad spinal condition. You should expect Medicare to pay for your rehabilitation as long as you are improving. This phase of care is call "active treatment." It will be shown on your Medicare claim form and payment reports with your service code. For example, "98940-AT."

PERHAPS-COVERED SERVICES

Your Chiropractic Adjustment must be clinically needed according to Medicare rules. If Medicare determines that your condition is not "Medically Necessary" they won't pay. If we know or believe that Medicare will not pay for your chiropractic adjustment, we will discuss this matter with you. We will also give you a special Medicare form known as the Advance Beneficiary Notice (ABN).

MY FINANCIAL RESPONSIBILITY

I have received the above information, "About Medicare Chiropractic Coverage." I understand that I am personally **financially responsible** for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, copayments, or non-covered services as may be required by my insurance plan.

x _____ _____

Signature of patient or person acting on patient's behalf — Date

MY AUTHORIZATION

I authorize the **release** of any medical or other information necessary to process my claims. I also **request** payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

x _____ _____

Signature of patient or person acting on patient's behalf — Date

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to a payer, your health information on this form may be shared with the payer. Your health information which the payer sees will be kept confidential by the payer.

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
1. Exams/Xray's 2. Spinal Adjusments for Maintinance Care 3. Adjustments of Extremities 4. Therapies ie: Massage, Electrical Stimulation, Therapeutic Excersise, Traction, Soft tissue therapy, Laser	1. Not covered if done by Chiropractor 2. Medicare doesn't cover Maintinance Care 3. Spinal Adjustments only are covered 4. Medicare does not cover therapy	1. $120-$220.00 2. $50 for spinal adjusment only 3. $20 extremity 4. $76-43, $10, $15, $10, $30, $30-$50

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

New Mexico Chiropractic Center

HIPAA = Health Information Portability and Accountability Act

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

I consent to the use or disclosure of my health information to New Mexico Chiropractic Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health bills or to conduct health care operations of New Mexico Chiropractic Center. I understand that diagnoses or treatment may be continued upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. New Mexico Chiropractic Center is not required to agree to the restrictions that I may request; however, if New Mexico Chiropractic Center agrees to the restrictions, the restriction is binding on New Mexico Chiropractic Center

I have the right to revoke this consent, in writing, at any time, except to the extent that New Mexico Chiropractic Center has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review New Mexico Chiropractic Center Notice of Privacy Practices prior to signing this document. New Mexico Chiropractic Center Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosure of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of New Mexico Chiropractic Center. The Notice of Privacy Practices also describes my rights and New Mexico Chiropractic Center duties with respect to my protected health information.

New Mexico Chiropractic Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative: _____

PRINT Name of Patient or Personal Representative: _____

Date: _____

New Mexico Chiropractic Center
X-RAY PREGNANCY WAIVER

I hereby acknowledge New Mexico Chiropractic Center has informed me prior to being x-rayed of the risk and the probable consequences of receiving x-rays during pregnancy. Prior to being x-rayed, I state of my own volition I am not pregnant and do hereby release and hold harmless New Mexico Chiropractic Center from any legal action or responsibility associated with the x-ray procedure.

Print Name: _____ Date: _____

Signature: _____