INSIGHT CHIROPRACTIC CENTER
4800 S SAGINAW STREET SUITE 1625 ~ FLINT, MI 48507
P: 810-275-9366 F: 810-213-0240

PATIENT INTAKE FORM

PATIENT INFORMATION: TODAY'S DATE: ______________________________

NAME: _________________________________ (Married Single Divorced Widowed)

ADDRESS: ____

RACE: ASIAN AFRICAN AMERICAN CAUCASIAN NATIVE AMERICAN HISPANIC OTHER

CITY/STATE/ZIP CODE: ____

PREFERRED PHONE: _________________________________ (home cell work)

ALTERNATE PHONE: _________________________________ (home cell work)

EMAIL ADDRESS___________________________________@_____________________________.COM

DATE OF BIRTH: _______ / _______ / _______ SOCIAL SECURITY: __________ - ______ - ________

ARE YOU CURRENTLY EMPLOYED?: YES NO RETIRED

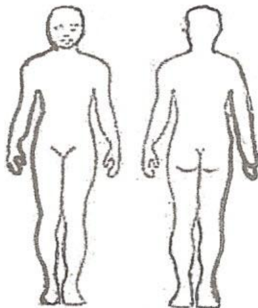
IF SO, WHAT IS YOUR OCCUPATION?: ____

EMERGENCY CONTACT: ____
Name *Relationship to patient* *phone*

INJURY/ACCIDENT INFORMATION:

CHIEF COMPLAINT (i.e. - Back Pain, Neck Pain, etc):
____ Date of Onset: ________ / ________ / ________

Please **shade** or **X** all areas on the diagram where you experience any pain:



Is the condition due to: Auto Accident, Work Accident, Slip and fall, Other *(please circle one)*?
Date of Accident: ________ / ________ / ________

Did you go to the Hospital after your injury: **YES** **NO** If yes, please state the name of the facility and if any CT Scans or MRIs were completed: ____

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Was there a report made of your injury? **YES** **NO**

To whom: (i.e. police, employer, insurance etc): ______________________________

Are you treating with any other doctors or physical therapy clinics: **YES** **NO** If yes, please list the names of the doctor/facility and phone number: ______________________________

____

INSURANCE INFORMATION:

PRIMARY HEALTH INSURANCE:

Company Name: ______________________________

ID/Claim Number: ____________________ Group Number: ____________________

Claim Representative: ____________________ Phone #: ____________________

If your Primary Health insurance is through a parent or spouse, please provide that person's name, relationship,and date of birth: ______________________________

Name *Relationship to patient* *Date of Birth*

SECONDARY INSURANCE:

Company Name: ______________________________

ID/Claim Number: ____________________ Group Number: ____________________

Claim Representative: ____________________ Phone #: ____________________

If your Primary Health insurance is through a parent or spouse, please provide that person's name, relationship, and date of birth:

____

Name *Relationship to patient* *Date of Birth*

ASSIGNMENT AND RELEASE:

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Insight Chiropractic Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____________________ ____________________

Patient signature Printed name, if signature is other than patient

____

If minor, parent/guardian signature

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NECK PAIN HISTORY

Please fill out only if you are experiencing neck pain. Otherwise, leave it blank.

Is your neck pain due to an injury or injuries? ____ YES ____NO

If yes, please describe the injuries and provide approximate dates. (Ex: slip on fall on the ice, 2011)

____

____

____

Please rate your neck pain, on a scale of 1-10, 10 being the worst pain you have ever felt?

Today: ______ / 10 On Average: ______ / 10

At its worst: ______ / 10 At its best: ______ / 10

How would you describe your neck pain? Check all that apply:

___Aching ___Burning ____Dull ____Numb _____Sharp ____Stabbing ____Throbbing

Other:____

____

Does anything make this pain better? _____YES _____NO

If yes, please explain:____

____

Does anything make this pain worse? _____YES _____NO

If yes, please explain:____

____

Does your pain radiate into other areas of the body, such as the arms, or do you have numbness/tingling and/or weakness? _____YES _____NO

If yes, please explain:____

____

Is your pain worse at a certain time of day? ____No ____Morning ____Afternoon ____Evening

Do you have frequent or severe headaches? _____YES _____NO

Please describe your headache:____

Do you or any family members have a history of stroke? _____YES _____NO

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MID BACK PAIN HISTORY

Please fill out only if you are experiencing mid back pain. Otherwise, leave it blank.

Is your mid back pain due to an injury or injuries? ____ YES ____NO

If yes, please describe the injuries and provide approximate dates. (Ex: slip on fall on the ice, 2011)

____

____

____

Please rate your mid back pain, on a scale of 1-10, 10 being the worst pain you have ever felt?

Today: ______ / 10 On Average: ______ / 10

At its worst: ______ / 10 At its best: ______ / 10

How would you describe your mid back pain? Check all that apply:

___Aching ___Burning ____Dull ____Numb _____Sharp ____Stabbing ____Throbbing

Other:____

____

Does anything make this pain better? _____YES _____NO

If yes, please explain:____

____

Does anything make this pain worse? _____YES _____NO

If yes, please explain:____

____

Does your pain radiate into other areas of the body, such as the legs, ribs, nec or upper back, or do you have numbness/tingling and/or weakness? _____YES _____NO

If yes, please explain:____

____

Is your pain worse at a certain time of day? ____No ____Morning ____Afternoon ____Evening

Do you have frequent or bladder or bowel issues? _____YES _____NO

If yes, please explain: ____

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LOW BACK PAIN HISTORY

Please fill out only if you are experiencing low back pain. Otherwise, leave it blank.

Is your low back pain due to an injury or injuries? ____ YES ____NO

If yes, please describe the injuries and provide approximate dates. (Ex: slip on fall on the ice, 2011)

____
____
____

Please rate your low back pain, on a scale of 1-10, 10 being the worst pain you have ever felt?

Today: ______ / 10 On Average: ______ / 10

At its worst: ______ / 10 At its best: ______ / 10

How would you describe your mid back pain? Check all that apply:

___Aching ___Burning ____Dull ____Numb _____Sharp ____Stabbing ____Throbbing

Other:____
____

Does anything make this pain better? _____YES _____NO

If yes, please explain:____

____

Does anything make this pain worse? _____YES _____NO

If yes, please explain:____
____

Does your pain radiate into other areas of the body, such as the legs, ribs, nec or upper back, or do you have numbness/tingling and/or weakness? _____YES _____NO

If yes, please explain:____

____

Is your pain worse at a certain time of day? ____No ____Morning ____Afternoon ____Evening

Do you have frequent or bladder or bowel issues? _____YES _____NO

If yes, please explain: ____

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GENERAL
- ❑ Weight loss or gain
- ❑ Fatigue
- ❑ Fever or chills
- ❑ Trouble sleeping
- ❑ Leg cramping

MUSCULOSKELETAL
- ❑ Muscle or joint pain
- ❑ Stiffness
- ❑ Back pain
- ❑ Redness of joints
- ❑ Swelling of joints
- ❑ Trauma

NEUROLOGIC
- ❑ Dizziness
- ❑ Fainting
- ❑ Seizures
- ❑ Weakness
- ❑ Numbness
- ❑ Tingling
- ❑ Tremor

HEMATOLOGIC
- ❑ Ease of bruising
- ❑ Ease of bleeding

SKIN
- ❑ Rashes
- ❑ Lumps
- ❑ Itching
- ❑ Dryness
- ❑ Color changes
- ❑ Hair and/or nail changes

HEAD
- ❑ Headache
- ❑ Head injury
- ❑ Neck pain

EARS
- ❑ Decreased hearing
- ❑ Ringing in ears
- ❑ Earache
- ❑ Drainage

EYES
- ❑ Vision loss/ changes
- ❑ Glasses or contacts
- ❑ Pain
- ❑ Redness
- ❑ Blurry or double vision
- ❑ Flashing lights
- ❑ Specks
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Last eye exam

NOSE
- ❑ Stuffiness
- ❑ Discharge
- ❑ Itching
- ❑ Hay fever
- ❑ Nosebleeds
- ❑ Sinus Pain

THROAT
- ❑ Bleeding
- ❑ Dry mouth
- ❑ Sore throat
- ❑ Non-healing sores

NECK
- ❑ Lumps
- ❑ Swollen glands
- ❑ Pain
- ❑ Stiffness

BREASTS
- ❑ Lumps
- ❑ Pain

RESPIRATORY
- ❑ Cough
- ❑ Coughing up blood
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Painful breathing

CARDIOVASCULAR
- ❑ Chest pain or discomfort
- ❑ Tightness
- ❑ Palpitations
- ❑ Shortness of breath with activity
- ❑ Difficulty breathing lying down
- ❑ Swelling
- ❑ Sudden awakening from sleep with shortness of breath

GASTROINTESTINAL
- ❑ Swallowing difficulties
- ❑ Heartburn
- ❑ Change in appetite
- ❑ Nausea
- ❑ Change in bowel habits
- ❑ Rectal bleeding
- ❑ Constipation
- ❑ Diarrhea
- ❑ Yellow eyes or skin

URINARY
- ❑ Frequency
- ❑ Urgency
- ❑ Burning or pain
- ❑ Blood in urine
- ❑ Incontinence
- ❑ Change in urinary strength

VASCULAR
- ❑ Calf pain with walking

ENDOCRINE
- ❑ Heat or cold intolerance
- ❑ Sweating
- ❑ Frequent urination
- ❑ Thirst
- ❑ Change in appetite

PSYCHIATRIC
- ❑ Nervousness
- ❑ Stress
- ❑ Depression
- ❑ Memory loss

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DOCTOR-PATIENT RELATIONSHIP

INFORMED CONSENT

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialists of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctors procedures often depend on environment, underlying causes and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Complex (VSC). When such vertebral subluxation complexes are found, chiropractic adjustments and ancillary procedures may be given in attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedure are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of vertebral subluxation complex. Since there are so many variables, it is difficult to predict the time schedule efficacy of chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, conditions, which do not respond to chiropractic care, may come under control or be helped through drugs or surgery. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of policy.

I have read and understand the foregoing.

____ ____________________

Signature Date

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NOTICE OF PRIVACY PRACTICES

Our office's Notice of Privacy Practice explains your rights and our policies regarding the protection of your personal health information. It is always kept here posted at the front desk. We are required by federal law to show it to you and get your signature to acknowledge that we have done so. If you would like, you may read it before you sign this or we can give you a copy to take home. Please sign below.

ACKNOWLEDGEMENT OF RECEIPT OF OFFICE PRIVACY POLICY

I acknowledge that Insight Chiropractic Center's "Notice of Privacy Practices" has been provided to me. I understand that I have the right to review Insight Chiropractic Center's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or in the performance of health care operations with Insight Chiropractic Center. It describes my rights as they concern the limited use of health information including my demographic information collected from me and created or received by my physician. The Notice of Privacy Practices for Insight Chiropractic Center is also provided on request at the main administration desk of the practice.

Insight 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 Date

____

Name of Patient of Personal Representative

____

Description of Personal Representative's Authority

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Patient Financial Responsibility Policy

At Insight Chiropractic Center, our goal is to provide the best service possible. Please call us before your appointment if you need to make special financial arrangements to pay your bill.

General

a. The patient's insurance policy is a contract between the patient and his or her insurance company. However, **all charges regardless of the insurance coverage are the patient's responsibility** and the patient is ultimately responsible for any unpaid balances. As a courtesy to our patients, Insight Chiropractic Center bills the patient's insurance and makes every effort to ensure that claims are promptly and correctly processed. Insight Chiropractic Center also bills patient's secondary insurance when patients provide complete insurance information.

b. Patient co-pays are expected at the time of service, and any remaining payment is due in full within 30 days of receiving the first bill from Insight Chiropractic Center. We accept cash, checks, money orders. If you can't pay your balance within 30 days, please contact us at P:810-732-8336. There are several ways you can pay your bill, including possible payment plans, and an Insurance Department representative will help find the right one for your financial needs. We will also work with you to determine if you are eligible for financial assistance.

Waiver of Co-Pays and Deductibles

a. It is the policy of this practice to bill all applicable out-of-pocket amounts and to make reasonable efforts to collect such amounts in accordance with our collection practices and procedures. Insight Chiropractic Center will not waive co-pay, coinsurance, or deductible amounts for insured patients, except in the limited circumstances set forth in this Patient Financial Responsibility Policy. Such determinations may be made only after sufficient investigation has been made and it is expected that such waivers will be *rare*.

b. If Insight Chiropractic Center does waive co-pays or deductibles for a patient based on the patient's financial status, we will maintain a record of the information upon which we based this decision. Waivers of co-pays and deductibles may also be made after reasonable collection efforts have failed to result in the collection of the fees. Insight Chiropractic Center will maintain records of what collection efforts have been made for fees waived in these instances.

____ ____________________

Signature of Patient or Personal Representative Date

____

Name of Patient or Personal Representative

____

Description of Personal Representative's Authority

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HIPAA AUTHORIZATION/RELEASE OF RECORDS/TRANSFER REQUEST

TO:____

____

I, ____, hereby authorize/request the release of my protected health information (PHI) i.e., all medical records including but not limited to diagnosis, records of treatment, examinations, x-rays, specialists seen, and disability dates (if applicable) to:

INSIGHT CHIROPRACTIC CENTER

4800 S SAGINAW STREET SUITE 1625

FLINT, MI 48507

P: 810-275-9366 F: 810-213-0240

I understand that I may inspect or copy the PHI described by this authorization. I understand that, at any time, this authorization may be revoked by me, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that information used or disclosed, pursuant to this authorization, could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Patient Signature:____

Patient Date of Birth:____

Today's Date:____