

NEW PATIENT INTAKE

Name: _____ Today's Date: _____

Address: _____ City _____ State _____ Zip _____

Home Telephone (*) _____ Work () _____ Cell () _____

We use text messaging for appointment reminders. Who is your cell phone company? _____

Email Address: _____ Male _____ Female _____

Social Security # _____ Birth Date: _____ Age: _____

Occupation: _____

Employer Name and Address: _____

Single _____ Married _____ Spouse's Name _____

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

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

YOUR HEALTH SUMMARY

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

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins and Needles in legs | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Pins and Needles in arms | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fever | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Problem urinating | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Menstrual irregularity | <input type="checkbox"/> Ulcers |

List any medications you are taking _____

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 _____

Functional Rating Index

For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please circle the one choice which most closely describes your condition right now.

1. Pain Intensity

No pain Mild pain Moderate pain Severe pain Worst possible pain

2. Sleeping

Perfect sleep Mildly disturbed sleep Moderately disturbed sleep Greatly disturbed sleep Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

No pain no restrictions Mild pain no restrictions Moderate pain; need to go slowly Moderate pain; need some assistance Severe pain; need 100% assistance

4. Travel (driving, etc.)

No pain on long trips Mild pain on long trips Moderate pain on long trips Moderate pain on short trips Severe pain on short trips

5. Work

Can do usual work plus unlimited extra work Can do usual work no extra work Can do 50% of usual work Can do 25% of usual work Cannot work

6. Recreation

No pain Mild pain Moderate pain Severe pain Worst possible pain

7. Frequency of Pain

No pain Occasional pain; 25% of the day Intermittent pain; 50% of the day Frequent pain; 75% of the day Constant pain; 100% of the day

8. Lifting

No pain w/heavy weight Increased pain with heavy weight Increased pain with moderate weight Increased pain with light weight Increased pain with any weight

9. Walking

No pain any distance Increased pain after 1 mile Increased pain after 1/2 mile Increased pain after 1/4 mile Increased pain with all walking

10. Standing

No pain after several hours Increased pain after several hours Increased pain after 1 hour Increased pain after 1/2 hour Increased pain with any standing

Name _____ Total Score _____

PRINTED

Signature _____

Date _____

Financial Policy

We may bill your insurance company as a courtesy to you. Please provide your current insurance information at your first appointment. If there are any changes in your insurance information, please alert the staff as soon as possible.

You are responsible to pay the estimated balance that your insurance will not cover. This balance is due at the time of service. We accept cash, checks, and debit/credit cards, including HAS and Care Credit.

By signing this document, you are acknowledging that you accept the following terms:

1. Payment for services rendered is due in full on the date of service.
2. Payment for equipment or supplements is due the day the order is made.
3. An interest fee will be added to all overdue balances.
4. An additional fee will be sent to all overdue balances sent to collections.
5. There is a \$25 charge on all returned checks with insufficient funds.

Lifetime Insurance Authorization

Please initial all items below:

_____ I understand that De Melo Chiropractic will verify my eligibility and benefits information to the best of their ability.

_____ I understand this does not guarantee payment by my insurance company or that all information will be correct.

_____ I request that payment of authorized benefits from my insurance policy or program be made to me or, on my behalf, to De Melo Chiropractic for any products/services furnished and provided to me.

_____ I authorize any holder of medical information about me at this office to release any information needed to determine these benefits or benefits for related services.

_____ I understand that I am financially responsible for all charges, whether or not paid for by my insurance company.

_____ I understand that it is not the responsibility of De Melo Chiropractic to inform me when my insurance benefits run out, and that I will be financially responsible for all services and products not covered by my insurance company once my benefits run out.

Patient Name (Please Print): _____

Parent/Guardian Name (if patient is a minor): _____

Patient/Parent/Guardian Signature: _____

OUR OFFICE POLICIES

Welcome to De Melo Chiropractic!

As a potential new patient, we feel it is important that you understand our office policies regarding how patients of this practice are cared for and the various methods we offer to facilitate payment for that care. Please read each policy carefully so that there is no misunderstanding as to what you can expect as a patient of this practice and what we expect in return. Once you have read "Our Office Policies", if you have any questions or if any of these policies are unclear to you and you would like further explanation before submitting your *Application for Care*, please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interest to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic care so that an informed decision can be made whether they wish to become a patient.

Over time, individuals who are accepted as patients at this office gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open setting, patients have a unique opportunity to observe firsthand the positive results that are achieved, and the benefits derived from being under chiropractic care. This knowledge and awareness reap a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about. You are encouraged to keep this document.

- **Patient Privacy** – Since the majority of patient care takes place in an open setting, it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy, it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter that you wish to discuss, please let us know and we will schedule a time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.
- **Your Care** – When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at *De Melo Chiropractic* rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctors use a myriad of techniques to accomplish this goal, including but not limited to Thompson Drop Technique, Activator Methods, and Palmer Diversified Chiropractic. It is important that you understand both the objective and the method(s) so that there is no confusion or disappointment. Tremendous progress has been made in the rehabilitation and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief through three distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving your overall health.
- **First Things First** – Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.
- **Patient's Report of Findings** – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case. Because the results of your X-Rays and all examinations, as well as the doctor's recommendations for care, will be discussed at that time, we strongly urge new patients to invite spouses or significant others to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

OUR OFFICE POLICIES

(signature page)

I have retained pages 1 of 2 of the 'Office Policies' document.

Patient or Guardian's Initials: _____

I hereby acknowledge receiving a copy of De Melo Chiropractic's 'Office Policies', a two-page document, the first page of which I have read and retained. This second page is recognized by me as the Signature Page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies' as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

Patient's Name

DOB

Patient or Authorized Person's Signature

Date

Witness Signature

Date

OUR PATIENT PRIVACY NOTICE

De Melo Chiropractic

This office is required to notify you in writing that, by law, we must maintain the privacy and confidentiality of our Personal Health Information (PHI). In addition, we must provide you with written notice concerning your rights to gain access to your PHI, and the potential circumstances under which, by law or as dictated by our Office Policy (see accompanying documents), we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, it will be provided to you. In addition, you will find we have placed several copies in report folders labeled HIPAA on tables in the reception area. Once you have read this notice, please sign the last page, and return it to our front desk receptionist. You are encouraged to keep this first page for your personal records.

Permitted Disclosures:

1. Treatment Purposes – discussion with other health care providers involved in your care.
2. Inadvertent Disclosures – open treating areas mean open discussion. If you need to speak privately to the doctor, please let our staff know so that we can place you in a private consultation room.
3. Payment Purposes – to obtain payment from your insurance company or any other collateral source.
4. Workers Comp. Purposes – to process a claim and/or aid in an investigation.
5. Emergency Purposes – to notify a family member in the event of a medical emergency.
6. Public Health and Safety – in order to prevent or lessen a serious or eminent threat to the health and/or safety of a person or general public.
7. Gov. Agencies/Law Enforcement – to identify and/or locate a suspect, fugitive, material witness or missing person.
8. Benefit Purposes – for military and national security members, prisoners, and government workers.
9. Deceased Persons – discussion with coroners and medical examiners in the event of a patient's death.
10. Notifications – we may call, text or email your home and leave messages regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of Ownership – in the event that this practice is sold, the new owners would have access to your PHI.

Your Rights:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the Patient Privacy Notice.
3. To request mailings to an address other than your residence.
4. To request restrictions on certain uses and disclosures and with whom we release information to, and to request amendments to information, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction is provided.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-Rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center to have copies made, we will happily accommodate you. However, you will be responsible for costs.
7. To file a formal complaint about how we handle your health information.

Complaints: If you wish to make a formal complaint about how we handle your health information, you can request the doctor's contact info at the front desk. If either is unavailable, you may make an appointment with our receptionist to see them within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights

200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

OUR PATIENT PRIVACY NOTICE

(signature page)

I have retained pages 1 of 2 of the 'Patient Privacy Notice' document.

Patient or Guardian's Initials: _____

I hereby acknowledge receiving a copy of De Melo Chiropractic's Patient Privacy Notice, the first page of which I have read and retained for my personal records. This second page is recognized by me as the Signature Page and will be retained by the practice as evidence of my receiving and understanding this 'Notice' I understand my rights, as well as this practice's duty to protect my PHI, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Patient Privacy Notice' at any time in the future and will make the new provisions effective for all information that it maintains, past and present.

I am aware that a more comprehensive version of this Notice is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any information I have received.

Patient's Name

DOB

Patient or Authorized Person's Signature

Date

Witness Signature

Date

