New Leaf Chiropractic
Sports and Family Wellness

Confidential Patient Intake Form

Name: _____ Age:_____ DOB: _____ Today's Date: _____

Address: _____City/State/Zip:_____

Phone # _____Email: _____

Gender: _____ Occupation: _____ Are you on Medicare Yes No ? (please circle one)

If not, would you like to have a Super-Bill/Itemized Receipt provided to you each month?:_____

Have you had previous chiropractic care? Please circle. Yes No Were X-rays taken? Yes No

Chiropractor/Office name: _____When was your last adjustment?_____

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

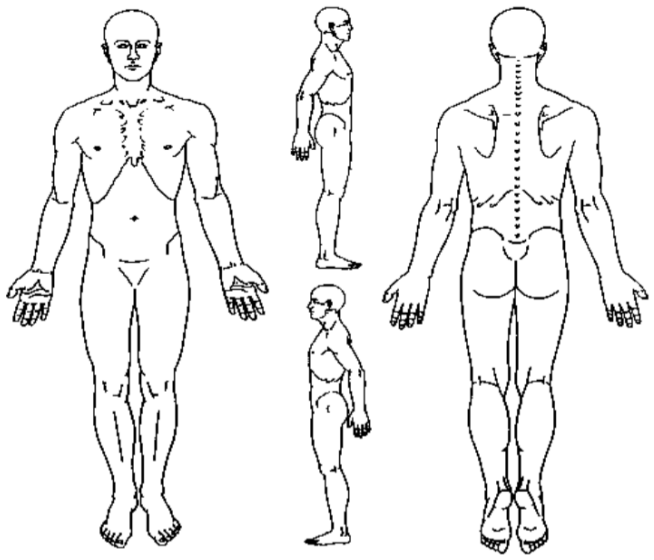
Do we have permission to send a thank you card to your referrer? Circle Yes / No

What brings you to our office? Please describe any problem areas or symptoms that you would like to address through treatment.

_____
_____
_____
_____
_____
_____
_____
_____
_____

On the diagram to the right, label your experience of your body.

A=Aching
C=Cramping
R=Throbbing
N=Numbness
B=Burning
D=Dull Pain
S=Stiffness
T=Tingling
O=Other _____



Please list any surgeries, major injuries, or accidents:

_____

_____

_____

Please list any medications you are taking:

_____

_____

We value knowing about your past experiences with chiropractic.
Would you please share with us your past experiences (or thoughts) about chiropractic? Can be positive and/or negative. If you have been under care please share with us what has/not worked and what you are looking for with us. We seek to learn from past experience to better optimize yours now.

_____

_____

_____

_____

_____

_____

_____

In the boxes below please check **(C) for all current symptoms** and **(P) for all past symptoms** you have had, even if they do not seem related to your current problem.

Headaches		Buzzing in Ears		Fatigue		Depression	
Loss of Smell		Sleep Problems		Cold Sweats		Anxiety	
Numbness - Toes		Diarrhea		Mood Swings		Pain - Cough/Sneeze	
Hot Flashes		Heartburn		Ulcers		Asthma	
Upset Stomach		Tension		Cold Feet		Allergies	
Dizziness		Neck Pain		Loss of Balance		Nervousness	
Pins/Needles - Legs		Difficulty Concentrating		Shoulder Pain		Low Back Pain	
Sinus Problems		Menstrual Irregularity		Hip Pain		Kidney Problems	
Numbness - Fingers		Cold Hands		Fever		Problems Urinating	
Pins/Needles - Arms		Bed Wetting		Irritability		High Blood Pressure	
Broken Bone(s)		Menstrual Issues		Eating Disorder		Stress Fractures	
TMJ Pain		Sensitive Eyes		Ear Infections		Fainting	
Stiff Neck		Constipation		Mid back Pain		Other:	
Cancer		Diabetes		Migraines		Other:	

Family Health Profile: Please mark any conditions which have affected your relatives.

Condition	Mother	Father	Grandparent	Sibling	Child	Spouse
Anxiety						
Arthritis						
Asthma						
Allergies						
Back Pain						
Constipation						
Difficulty Sleeping						
Spinal Disc Issues						
Ear Problems						
Fatigue						
Fibromyalgia						
Headaches/ Migraines						
High Blood Pressure						
Neck Pain						
Numbness						
Scoliosis						
Digestive Issues						
Sinus Issues						

Signature: _____ Date: _____
Signature of Parent or Guardian (if patient is under 18) _____

Pregnancy Release (Females Only). *X-ray radiation could be hazardous to an unborn child. By signing below I verify to the best of my knowledge that I am not pregnant and give permission for X-rays to be taken at New Leaf Chiropractic if necessary.*

Date of last menstrual period: _____

Signature: _____ Date: _____
Signature of Parent or Guardian (if patient is under 18) _____

FINANCIAL POLICY

At **New Leaf Chiropractic & Family Wellness**, we understand that the cost of healthcare is a key concern for our patients. Your care is our main priority, but we hope that you will assist us by understanding your responsibility as it relates to our Financial Policy. If you have any questions regarding our policy a member of our staff will be glad to assist you. We are an out-of-network provider, and are able to provide you with a written summary statement of your charges so that you may submit directly to your insurance company (aka the Superbill). You are expected to pay in-full at the time of your visit and to assist this we accept cash, HSA accounts, credit cards (MasterCard, Visa, Debit) and personal checks.

When you pay by check you expressly authorize this office (Brothers Buck PC), if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check, plus a processing fee of $25 and any applicable sales tax. The use of a check for payment is your acknowledgment and acceptance of this policy and its terms.

Accepting assignment and/or liens is done so under a pre-qualified understanding between the patient, this office, and the third party payor(s). Establishing an honest ethical working relationship allows this office to continue accepting liens and assisting patients in their goals for better health. Any and all changes of the original party's agreement, independent of this office's knowledge or consideration, immediately disqualifies the terms of that agreement and demands immediate payment on the outstanding balance.

Financial arrangements are valid under your present condition. Should changes arise in your medical or financial situation that would affect your current financial agreement, you must notify this office prior to your care. Should you discontinue care or be released from further service at this office, all outstanding balances are due upon notification. Any past due balance not paid **within 90 days** will be reported to the credit bureau and turned over to an attorney or agency for collections. You will be held liable for up to 50% of the balance owed for the collection fees associated with past due accounts. Please keep your account current to avoid any action or blemish on your credit history. We are happy to put pre-2019 physical x-rays on loan, however any x-rays checked out from the office and not returned within 30 days will be subject to a $250 collection fee as these are part of your permanent record at Brothers Buck, PC. Digital X-rays can be emailed with a signed email release for no charge.

Thank you for your understanding of our Financial Policy. Please let us know if you have any questions. **I have read, understand and agree to this Financial Policy in its entirety.**

Printed Name:_____

Signature: _____ Date:_____

Signature of Parent or Guardian (if patient is under 18) _____

PATIENT PRIVACY

This practice is committed to maintaining the privacy of your **P**rotected **H**ealth **I**nformation (**PHI**), which includes information about your health condition and the care you receive from the practice. This notice details how this information may be used in this office. With consent from you, it is the policy of this office to use the your PHI in the following manners:

1. Treatment: Your PHI will be given to those professionals that require it to provide care.
2. Appointment reminders: Our staff may call/text/email from time to time to remind you of appointments
3. Sign-in Log: We maintain a log of incoming patients for our own scheduling/statistical use
4. Referral board: We keep a board to thank members of our practice who have referred others
5. Medical Doctors: It is the policy of this office to share our findings with your regular medical doctor. This helps build a better understanding of how we may work together to improve your health.
6. Email: We have compiled a database of "all things health" and we will add you immediately to this list for you and your family's convenience. We never "spam." In fact, we dislike it as much as you. You have the right to easily unsubscribe from future emails with a "one-click" option from any previous email

In special circumstances, your PHI may be disclosed as in the following:

1. Personal Representative: In accordance with applicable law that may represent you
2. Emergency situations
3. Abuse, Neglect, or Domestic Violence
4. Law Enforcement issues
5. Worker's Compensation claim
6. Avert a health threat

Your rights regarding your health information:

1. Right to inspect and copy your records: A written request must be submitted and cost of copying may be applied to such a request
2. Amend your PHI by submitting a written request with an explicit reason.
3. Request restrictions on your PHI. However, this practice is not obligated to agree to any such restrictions
4. Revoke consent at any time

Printed Name: _____

Signature: _____ Date:_____

Signature of Parent or Guardian (if patient is under 18) _____

INFORMED CONSENT

The primary treatment used by a Doctor of Chiropractic is a specific spinal adjustment - Based on the findings from an examination, movement assessment, and history, we will determine if an adjustment is appropriate to facilitate your health goals. Each person is different, and each adjustment and exercise is given based on the specific nature of the individual.

The nature of the chiropractic adjustment - An adjustment is the specific application of forces to facilitate the body's correction of joint movement. Our chiropractic method of correction is by mobilization of the spine and extremity joints. We will use our hands and/or a mechanical device (called an *Activator*), and therapeutic exercises to improve how your body moves and feels to fully express itself.

The material risks inherent in chiropractic adjustment - As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations, and muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. It should be noted that we rarely adjust the upper neck, and do so only when findings indicate that it is warranted

The probability of those risks occurring - Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during your health history and examination. Stroke has been the subject of tremendous disagreement within and outside the profession with one prominent authority/researcher (Haldeman, Scott, D.C., M.D.) saying that there is **at most** a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

Lastly - Our clinic has open adjusting/treatment areas. By signing below you acknowledge the doctor will be adjusting you and may discuss your condition and chiropractic care regimen in this shared treatment area. If you have any questions or wish to discuss your condition in private you always have the option to schedule a time with the doctor in the private consultation/exam room.

Text message notifications - By signing below you agree to receiving text messages regarding your appointments. You are welcome to use the line to communicate with the doctors and front desk if you have any questions about care, cancellations, or rescheduling appointments. If you want to opt out of receiving these messages, check the box below.

- ❑ OPT OUT of receiving appointment reminders via text

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment(s) & have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved & give my consent to accept chiropractic care on this basis.

Printed Name:_____

Signature: _____ Date: _____

Signature of Parent or Guardian (if patient is under 18) _____

_____ _____ _____

Signature of witness Printed name of witness Date