Patient Intake Form

Today's Date: _____

Welcome to Stamos Chiropractic Inc. Thank you for taking a moment to fill in our Patient Intake Form. Please fill this form completely and to the best of your knowledge. Be sure to sign the consent and authorization form on page 4 and 5.

Patient Information

Personal Information

First Name: _____
Last Name: _____
Gender: ☐ Female ☐ Male

Date of Birth: _____ Age: _____
Social Security #: _____-_____-_____
Height: _____ Feet _____ Inches
Weight: _____

Marital Status: ☐ Married ☐ Single

Preferred Language: English Spanish Other:_____

Occupation: _____

Referred By: _____

Emergency Contact

Contact Name: _____
Relationship: _____
Phone: _____

Contact Information

Email: _____
Home Phone: _____
Cell Phone: _____

Home Address

Address Line 1 _____
Address Line 2 _____
City: _____
State: _____
Zip/Postal Code: _____

If patient is a minor, Parent/Legal Guardian Contact Information

First Name: _____
Last Name: _____
Phone: _____
Address: _____
City, State _____ _____
Zip Code: _____

Insurance Information

Who is the policy holder? _____
Relationship to Patient: _____
Insurance Company: _____
Policy Number: _____
Primary Policy Holder Information
Date of Birth: _____
Social Security #: _____-_____-_____

Accident Information

Is condition due to an accident? ☐ Yes ☐ No
Date of accident: _____
Type of accident: ☐ Work ☐ Auto ☐ Home ☐ Other _____
To whom have you made a report of your accident? ☐ Auto Insurance ☐ Employer ☐ Workman's Comp ☐ Other _____
Attorney's Name: _____

Current Symptoms

Patient Condition:

1. What is your **worst** complaint?_____
   When and **how** did your condition begin?_____

   Rate your pain/ discomfort on a scale (circle) **None = 0 1 2 3 4 5 6 7 8 9 10 = Severe**

   How often do you experience this complaint (circle) Occasionally (0-25% of the day) Intermittently (26-50% of the day) Frequently (51-75% of the day) Constantly (76-100% of the day)

   How are your symptoms changing? **Improving** **Not Changing** **Worsening**

2. What is your **2nd worst** complaint?_____
   When and **how** did your condition begin?_____

   Rate your pain/ discomfort on a scale (circle) **None = 0 1 2 3 4 5 6 7 8 9 10 = Severe**

   How often do you experience this complaint (circle) Occasionally (0-25% of the day) Intermittently (26-50% of the day) Frequently (51-75% of the day) Constantly (76-100% of the day)

   How are your symptoms changing? **Improving** **Not Changing** **Worsening**

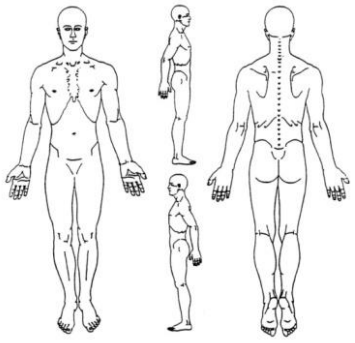
3. Briefly describe any other complaints:_____
   _____

Type of Pain: Circle **Sharp Dull Weakness Numbness Aching Shooting Burning Stiffness Other**

Activities That Are Painful: **Sitting Standing Bending Walking Laying Down**

Does the Pain Interfere with… **Sleep Work School Daily Routine Recreation**

What Treatments Have You Already Received For This Condition? **Medication Surgery Chiropractic Physical Therapy Other_____**



Please indicate on the diagram to the left where you are experecing your symptoms

How were you referred to our office? Flyer( ) Postcard( ) Walk By( ) Other( ) Doctor / Friend( ) Who? _____
Have you ever had chiropractic care before? (YES / NO) If yes, when was your last treatment? _____
Have you ever had a professional massage before? (YES / NO) If yes, when was your last massage? _____
What are your health goals? (Check one of the following)
( ) Reduce symptoms only **( )** Reduce symptoms and show me how to prevent flair-ups **( )** Reduce symptoms, prevent flair-ups and maintenance care

Review of Systems

Name of your family physician _____Last appointment with your physician _____Phone # _____
Do you give us permission to send your medical doctor an updated report on your status? (YES / NO)
Have you been hospitalized in the past? (YES / NO) If yes when and why? _____

Check any of the following symptoms you are currently experiencing or have experienced within the past 6 months.

Musculoskeletal
__Low Back Pain
__Pain Between Shoulders
__Neck Pain
__Headaches
__Arm Pain/Numb/Tingling
__Leg Pain/Numb/Tingling
__Joint Pain/Stiffness
__Walking Problems
__Difficulty Chewing
__Weakness

EENT
__Vision Problems
__Dental Problems
__Sore Throat
__Ear Pain/Ringing
__Hearing Difficulty

General
__Allergies
__Loss of Sleep
__Fever/Night Sweats
__Eczema (skin rash)
__Weight Loss/Gain

Genitourinary
__Bladder Trouble
__Painful Urination
__ Excessive Urination
__Discolored Urine

Male Specific
__Difficulty Urinating
__Impotence
__Sterility

C-V-R
__Chest Pain
__Short of Breath
__Blood Pressure
__Heart Problems
__Wheezing
__Lung Problems
__Varicose Veins
__Arm/Leg Swelling
__Asthma
__High Cholesterol
__Bruise Easily

Female Specific
__Menstrual Irregularity
__Menstrual Cramping
__Sterility
__Breast Pain

ARE YOU PREGNANT? (YES / NO)

Nervous
__Numbness
__Paralysis
__Dizziness
__Forgetfulness
__Confusion
__Depression
__Fainting
__Convulsions
__ADHD/Hyperactivity
__Anxious
__Tremor/Shaking

Gastrointestinal
__Gas/Bloating
__Heartburn
__Poor Appetite
__Excessive Appetite
__Excessive Thirst
__Decreased Appetite
__Colitis
__Vomiting
__Diarrhea
__Constipation
__Black/Bloody Stool
__Liver Problems
__Abdominal Pain
__Frequent Nausea

Past Medical History

Social History

Exercise	Work Activity	Habits	
☐ None	☐ Sitting	☐ Smoking	Packs/Day _____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week _____
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day _____
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason _____

Medications	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History

Car Accidents _____
Falls _____
Head Injuries _____
Broken Bones _____
Surgeries _____
Ongoing Illnesses _____
X-Rays, MRIs & Special Imaging _____

PATIENT SIGNATURE _____ **DATE** _____

Privacy Policy Notice

Consent for the use and/or disclosure of protected health information to carry out treatment, payment and/or health care operations.

Through this consent form, Stamos Chiropratic Inc. is notifying you and you agree that:

1. Protected health information may be used and/or disclosed in order to carry out treatment, payment or health care operations.
2. We will only disclose protected health information with your expressed written authorization.
3. A notice containing the office's privacy practice, including a more complete description of uses and/or disclosure necessary to carry out treatment, payment and/or health care operations, is available for you to read, and you are hereby encouraged to do so prior to signing this consent form.
4. This office reserves their right to change its privacy practices that are described in the above referenced notice, in accordance with applicable law, and will make available to all patients any and all revised and current notices.
5. You have the right to request that this office restrict how protected health information is used and/or disclosed to carry out treatment, payment and/or health operations.
6. You have the right to inspect your records and amend or correct health information.
7. If this office agrees to a requested restriction it will take approximately 30 days to do so.
8. You have the right to revoke this consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that this office has already taken action in reliance on this consent.
9. Should you revoke this consent at any time, the office retains the right to refuse treatment based upon the revocation and the future lack of such consent.
10. You will sign and date all consents requested to which you agree.
11. I hereby authorize Stamos Chiropractic Inc./ Dr. Alison Stamos to use and/or disclose health information for the purpose of filing your health insurance claims, consult with other health care providers, and for billling purposes.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Name of Individual (printed) Signature of Individual

_____ _____

Signature of Legal Representative
(Attorney-in-fact, Guardian, Parent of a minor, etc…)

Relationship

Date Signed ____/____/____

_____

Witness – Stamos Chiropractic Inc.

This consent/authorization form will be valid for one year from date of signing.

Consent to Treatment

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare occasions case injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/ strain injuries, irritation of a disk condition and rarely fractures. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke: rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of stroke. In essence, there may be a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with an upper cervical adjustment is extremely remote.

If deemed necessary the use of Rock Tape will be used, this may cause skin irritation or even a rash. If you have a skin condition, please notify the doctor.

I understand and agree that health/ accident insurance policies are an arrangement between an insurance carrier and me. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health, and in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed before treatment. In addition, they will help us to determine if there is any reason to modify your care or provide you with a referral to another health care provider.

I understand and agree that all services rendered will be charged to me, and I am responsible for timely payment of such services.

I also understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including chiropractic adjustments and other modalities as reported following my assessment.

I certify that I am the patient or legal guardian listed below. I have read/ understand the included information and certify it to be true and accurate to the best of my knowledge.

_____ _____

Patient Name (printed) Signature of Patient or Legal Guardian

_____ _____

Patient's Legal Guardian (printed) Relationship

Date Signed ____/____/____ _____

Witness – Stamos Chiropractic Inc.

OFFICE POLICIES / PROCEDURES AGREEMENT AND CUSTOMARY FEE SCHEDULE

FINANCIAL ARRANGEMENTS

I understand and agree that health and accident policies are an arrangement between an insurance company carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

INSURANCE BILLING/PAYMENT

Patients are ultimately fully responsible for services provided by our office. For your convenience, our office will make an effort to verify your insurance benefits. However, please note that verification of benefits is not guaranteed. Your insurance company makes the final determination of insurance benefits when they consider the claim. Patients are fully responsible for payment of services not authorized or covered by their insurance company. Patients that are represented by an attorney in PI cases must notify our office the same day if changing or canceling representation.

PAYMENT ARRANGEMENTS

We understand that occasions arise when it may be necessary for you to request to be billed rather than pay at the time of service. This may include setting up a payment plan for those who may require extensive treatments. Payment is due within 30 days of the service rendered. If there are legitimate financial problems, please discuss them with our office manager prior to the 30 days so that we may find a workable solution. If an account is not paid within 30 days and no payment arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. You will also be charged a monthly interest of 10% based off your principal balance until all fees are paid.

APPOINTMENT SCHEDULING

Canceling or rescheduling appointments requires a 24 hour notice otherwise you will be charged a fee for the missed scheduled service.

NOTICE OF PRIVACY POLICY

We are required by law to make sure your medical information is protected; give you notice describing our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect. By signing below you are acknowledging that you have received our Notice of Privacy Policy.

NOTICE OF PRIVATE PRACTICES/ BUSINESSES

There are separate practices/ businesses within this office. Each entity is owned and operated as separate businesses and may have separate fee schedules, different treatment techniques and patient management. I understand that each service offered at this facility are owned and operated as separate businesses and hold each business harmless from any act or omission which may occur by any of the other businesses during the course of my treatment at this facility. Circumstances may arise such as emergencies, or doctor vacation or sick leave and you may request to be treated by another doctor within this office. If you are treated by another doctor you may be charged a different fee. Please consult with our office manager before your treatment if you have any questions.

CURRENT CUSTOMARY FEE SCHEDULE OF OUR MOST COMMON FEES

You may request a statement or receive an insurance explanation of benefits (EOB) which will reflect services provided and the associated insurance billing codes which are shown below. If you have any questions about your EOB or bill please discuss them with our office manager. These fees may change without notice. We will provide a copy of this form if requested.

Initial Exam	99201	Limited	$70.00	**Re-Exam**	99211	Minimal	$30.00	
(New Patient)	99202	Expanded	$120.00	*(Established Patient)*	99212	Limited	$70.00	
	99203	Detailed	$165.00	*(Treated within 3 years)*	99213	Expanded	$115.00	
	99204	Comprehensive	$255.00		99214	Detailed	$170.00	
Range of Motion	95851	$50.00		**Muscle Testing**	95831	$50.00	**Physical Performance Testing**	97750 $50.00
Chiropractic Adjustments	98940	$45.00	1-2 regions	**Manual Therapies**	97140	$50.00		
	98941	$65.00	3-4 regions				**Electrical Muscle Stimulation**	97014 $25.00
	98942	$80.00	5 regions	**Therapeutic Exercises**	97110	$50.00 / Unit		
	98943	$40.00	Extremities					
				Therapeutic Activities	97530	$55.00 / Unit	**Ultrasound**	97035 $20.00
Massage	97124	$40.00 / Unit						
	Ex. 30 min = $80.00			**Mechanical Traction**	97012	$25.00	**Neuromuscular Ed**	972112 $55.00

X-Rays	**Cervical Spine**			**Thoracic Spine**			**Lumbar Spine**	
	72040	$90.00	2-3 views	72070	$90.00	2 views	72100 $100.00	2-3 views
	72050	$125.00	4 views	72072	$105.00	3 views	72110 $125.00	4 views
	72052	$150.00	5 views	All X-ray fees are not listed such as extremities. Ask the front desk for these fees.				

_____ PRINT NAME

_____ SIGNATURE

_____ DATE

Stamos Chiropractic Inc.—4 10 S. Melrose Dr. Ste. 200 Vista, CA 92081—Ph: 760.630.0683 Fax: 760.630.7715

Stamos Chiropractic Inc.

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of **Stamos Chiropractic Inc.**

I understand that the Notice describes the uses and disclosures of my protected health information by **Stamos Chiropractic Inc.** and informs me of my rights with respect to my protected health information.

Patient's Signature or that of Legal Representative

Printed Name of Patient or that of Legal Representative

Today's Date

If Legal Representative, Indicate Relationship

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____

Employee Name

Today's Date