Patient Name_____ Birthdate_____ Date _____
SS #/SIN_____ □ Male □Female Home phone_____ Cell Phone _____
Check appropriate Box: □Minor □Single □Married □Divorced □Widowed □Separated
Patient's Address _____City _____ State_____ Zip_____
Employer Name: _____
Spouse or Patient's Guardian name_____ Spouse's Employer _____
Whom may we thank for referring you? _____
Person to contact in case of an emergency_____Phone _____
In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

_____ _____
*Parent or Guardian* *Date*

**Responsible Party**
Name of The Person responsible for this account _____Relationship to Patient _____
Address _____ Home Phone _____
E-Mail _____ Birthdate _____ Cell Phone _____
Driver's License # _____ Is the person currently a patient at our office? □ Yes □ No
**Do you have any Medical insurance?** □ Yes □ No if yes, complete the following:
Name of the insured_____ Relationship to patient_____
Birthdate_____ SS#/SIN_____ Name of Employer_____
Work Phone _____Address of Employer _____
Insurance Company_____ Group #_____ Union or local # _____
Ins. Co. Address _____

## Health History

Patient Name: _____DOB: _____Date:_____

**Chief Complaint:** _____

### History of Present illness:

**Location**: _____ (Where is the pain/problem?)
**Quality:** _____ (Aching, sharp, shooting, burning, cramping, etc)

**Severity:** _____ (How severe on a scale of 1-10 with 10 being the most severe?)
**Duration:** _____ (How long have you had this pain/ problem? When did it start?)

**Timing**: _____ (Does the pain/problem occur at a specific time?)
**Context:** _____ (Where were you at the onset of this pain/problem?)

### Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Anemia.....NO | YES | Back Trouble.....NO | YES | Hepatitis.....NO | YES | Bladder Infection.....NO | YES |
| High Blood Pressure.....NO | YES | Ulcer.....NO | YES | Chicken Pox..... NO | YES | Seizures.....NO | YES |
| Low Blood Pressure.....NO | YES | Kidney Disease.....NO | YES | Migraine Headaches..... NO | YES | Thyroid Disease.....NO | YES |
| Tuberculosis.....NO | YES | Bleeding Tendency.....NO | YES | Blood Transfusion.....NO | YES | Mitral Valve Prolapse....NO | YES |
| Diabetes.....NO | YES | Asthma.....NO | YES | Cancer.....NO | YES | Eczema.....NO | YES |
| Pneumonia.....NO | YES | Polio.....NO | YES | AIDS & HIV.....NO | YES | Glaucoma.....NO | YES |
| Arthritis..... NO | YES | Hernia.....NO | YES | Bronchitis.....NO | YES | Stroke ..... NO | YES |

Other: _____

| **Previous Hospitalizations/Surgeries/Serious Illnesses** | When? | Hospital, City, State |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Name:_____ DOB _____ Date:_____

**Medication:** REFER TO EHR FOR MEDICATION LIST
**ALLERGIES:** REFER TO EHR FOR ALLERGY LIST

## Patient Social History:

| | | | | | |
|---|---|---|---|---|---|
| Marital Status | Single: _____ | Married: _____ | Separated: _____ | Divorced: _____ | Widowed: _____ |
| Use of Alcohol | Never: _____ | Rarely: _____ | Moderate: _____ | Daily: _____ | |
| Use of Tobacco | Never: _____ | Rarely: _____ | Moderate: _____ | Daily: _____ | |
| Use of Drugs | Never: _____ | Type/Frequency: _____ | | | |

Excessive Exposure
At home or at work to: Fumes: _____ Dust: _____ Solvents: _____ Airborne Particles: _____ Noise: _____

## Family Medical History: REFER TO EHR FOR FAMILY MEDICAL HISTORY

## Review of Systems: *Please Indicate which of the below you have experienced in the last month*

| Eyes/Ears/Nose/Throat/Respiratory | | | Musculoskeletal | | | General | | |
|---|---|---|---|---|---|---|---|---|
| Blurred vision/ double vision | Yes | No | Multiple Joint Pain | Yes | No | Fatigue | Yes | No |
| Asthma | Yes | No | Muscle Aches/ spasms | Yes | No | Weakness | Yes | No |
| Stuffy Nose | Yes | No | Neck Pain | Yes | No | Weight loss or gain | Yes | No |
| Sore throat | Yes | No | Low Back Pain | Yes | No | Nausea | Yes | No |
| Chronic Cough | Yes | No | Ankle or foot pain | Yes | No | Vomiting | Yes | No |
| Chest Congestion | Yes | No | Hip Pain | Yes | No | Diarrhea | Yes | No |
| Frequent Sneezing | Yes | No | Wrist/Hand Pain | Yes | No | Constipation | Yes | No |
| Itchy/Watery Eyes | Yes | No | Elbow Pain | Yes | No | Forgetfulness | Yes | No |
| Drainage | Yes | No | Shoulder Pain | Yes | No | **Neurological** | | |
| Earache or Ear Infection | Yes | No | Knee Pain | Yes | No | Balance problems | Yes | No |
| Hoarseness | Yes | No | | | | Headaches | Yes | No |
| Wheezing | Yes | No | | | | Migraines | Yes | No |
| Shortness of Breath | Yes | No | | | | Dizziness | Yes | No |
| Wheezing | Yes | No | | | | Numbness | Yes | No |
| | | | | | | Tingling | Yes | No |
| | | | | | | Burning pain | Yes | No |

**If any of the above were answered as yes, please explain** _____

*To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.*

_____ _____
**Signature of the Patient, Parent or Guardian** **Date**

_____ _____
Provider Signature Date

Name:_____ DOB _____ Date:_____

*ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY:*

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Balance Medical and Rehab** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been* or *will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

**Signature of Patient/ Personal Representative: _____ Date: _____**

*GENERAL CONSENT FOR CARE*:

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to medical care and treatment, as ordered by a provider, while such medical care and treatment is provided through Balance Medical and Rehab on an outpatient/ office visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations at Balance Medical and Rehab. This consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

**Signature of Patient/ Personal Representative: _____ Date: _____**

*ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION:*

I acknowledge that I have received Balance Medical and Rehab's Notice of Privacy Practices for protected health information.

**Signature of Patient/ Personal Representative: _____ Date: _____**

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Documentation of Good Faith Effort to Obtain Written Acknowledgement:

I made a good faith effort to obtain the patient's written acknowledgement of our Notice of Privacy Practices for protected health information by showing the patient the Notice of Privacy Practices in our office, however, I was unable to obtain the patient's written Acknowledgement because (check all that apply):

- ○ The patient refused to sign this form
- ○ Other (explain in detail) _____

**Staff Member Name: _____ Date: _____**

Notes: This written Acknowledgement must be completed no later than the first date of health care services or treatment is provided to the patient after January 1, 2008. This Acknowledgement must be retained in the patient's permanent record.

Name:_____ DOB _____ Date:_____

*CONSENT FOR COMMUNICATION:*

We have the ability to call or text you, reminding you of your appointments. Patients in our practice may be contacted via phone/text message to be reminded of an appointment, to obtain feedback on an experience within our office, and to provide general health reminders/information. By initialing, you are consenting to receive appointment reminders and other health care communications via telephone or text from Balance Medical and Rehab. Understand that you can opt out of telephone reminders or text messaging by providing a written request to the office. **_____ (initial)**

*FINANCIAL POLICIES*:

We are committed to providing you the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibilities.

DEDUCTIBLES AND CO-PAYMENTS- By law we MUST collect your carriers designated co-payment at the time of service. Please be prepared to pay your deductible or co-payment each visit.

NON-COVERED SERVICES- In the event that your policy does not cover the cost for therapeutic modalities (i.e. muscle stimulation), x-rays, and/or re-examinations, you will be responsible for the cost of those services. We cannot guarantee insurance payment as we are not the insurance carrier. As a courtesy our office will confirm your coverage. Since we often are given misinformation it is our suggestion that you also confirm your medical and chiropractic coverage. If claims are delayed by more than three months, we require you to reimburse our office in full for services rendered. YOU WILL BE RESPONSIBLE FOR ANY AND ALL EXPENSES INCURRED IN OUR OFFICE**.**

PATIENTS WITHOUT INSURANCE COVERAGE- Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

MEDICARE- We will submit charges to Medicare at the Medicare-allowed amount. The patient will be responsible for non-covered services, the annual deductible and 20% of billed services. A secondary/co-insurance can be billed if you have one.

There is a $25.00 service charge for all returned checks.

I understand that failure to pay outstanding balances or make payment arrangements within 90 days, the amount due will be considered delinquent and subject to legal action or assignment to a collection agency or attorney. I further agree to pay for reasonable collection and attorney fees.

MISSED APPOINTMENTS- It is important to make your scheduled office visits, or let the office know if you cannot make it. If an appointment is missed without a 24-hour notice, you will be charged at $35 missed office visit fee.

CREDIT CARD/ DEBIT ON FILE (Required)- I agree to place a major credit card on file with the Balance Medical and Rehab and hereby authorize you to charge my credit card for any delinquent balances over sixty days.

My signature below indicates that I have reviewed and accept the financial policies of Balance Medical and Rehab.

**Signature of Patient/ Personal Representative: _____ Date: _____**

# Electronic Health Records Intake Form

*This form complies with CMS EHR incentive program requirements*

**Patient Name _____Email** _____@_____

**Preferred method of communication for patient reminders** (Circle one): Email / Phone / Mail

**DOB:** ____/____/_____ **Gender (Circle one):** Male / Female **Preferred Language: _____**

**Smoking Status (Circle one):** Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked
**Smoking Start Date (Optional): _____**
**Race (Circle one):** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer
**Ethnicity (Circle one):** Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

| **Family History** | | | |
|---|---|---|---|
| **Age** | | **Disease** | **If deceased, cause of death** |
| *Father* | | | |
| *Mother* | | | |
| *Siblings* | | | |
| *Children* | | | |

| **Are you currently taking any medications?** *(Include regularly used over the counter medications)* | |
|---|---|
| Medication Name | Dosage and Frequency (i.e. 5mg once a day, etc.) |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

| **Do you have any medication allergies?** | | | |
|---|---|---|---|
| Medication Name | Reaction | Onset Date | Additional Comments |
| | | | |
| | | | |
| | | | |

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

***For office use only***

Height: _____ Weight:_____ Blood Pressure:L/R _____/_____ Pulse _____