CORDOVA CHIROPRACTIC AND WELLNESS

Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name: _____ Date: _____

Address: _____

_____

SSN: _____ □ Male □ Female Age: ____

Date of Birth: _____

Email: _____

Phone: _____ Cell Phone: _____

Occupation:_____ Employer:_____

Do you have insurance that covers chiropractic? Yes No

Primary Insurance: PPO HMO Other _____

Patient Name:_____DOB: _____

Subscriber Name:_____DOB: _____

Primary Insurance Blue Cross Blue Shield Aetna Cigna Other _____

Patient's Relationship to Subcriber:_____

ID Number:_____Group #: _____

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

Have you had chiropractic care before? Yes No

If so, when and who was the doctor / clinic? _____

Do you have a Family Doctor? Yes No Name of Doctor _____

Phone Number _____City _____Last Visit _____

Circle all that apply

1) How often do you experience symptoms? Rarely (0-26%) Occasional (26-50%) Frequent (51-75%) Constant (76-100%)

2) Describe the nature of your symptoms: Sharp/Shooting, Dull Ache, Tingling, Headache, Radiating Pain, Inflammation, Throbbing Pain on Movement, Numbness, Burning

3) Have you had similar symptoms in the past? Yes/No

4) Since your problem began, is the pain: Getting Better, Not Changing, Getting Worse

5) What makes your symptoms worse? Sitting, Standing, Walking, Bending, Lifting, Sleeping, Reaching Lying Down, Movement, Stretching/Exercise, Nothing Other_____

6) What makes your symptoms better? Sitting, Standing, Lying Down, NO movement, Movement, Heat Medication, Rest, Stretching/Exercise, Adjustments Other_____

7) How much has your pain interfered with your normal work (including housework)? Not at all, A little bit, Moderately, Quite a bit, Extremely

8) How much time has your condition interfered with your social activities? All of the time, Most of the time, Some of the time, A little of the time, None of the time

9) Who have you seen for your current symptoms? No one, Chiropractor, Medical Doctor, Physical Therapist, Other :_____

10) What tests have you had for your current symptoms? X-rays, MRI, CT Scan, Massage Therapist, Lab work (blood, urine, etc.) Other_____

Patient Intake Form

Give a brief detailed description of the problem you are currently experiencing: _____

_____

_____

_____

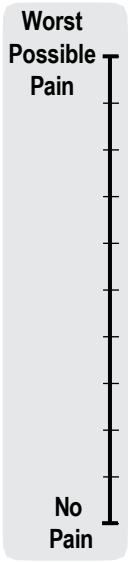
How long have you had this condition? _____ Is it getting worse? □ yes, □ no _____

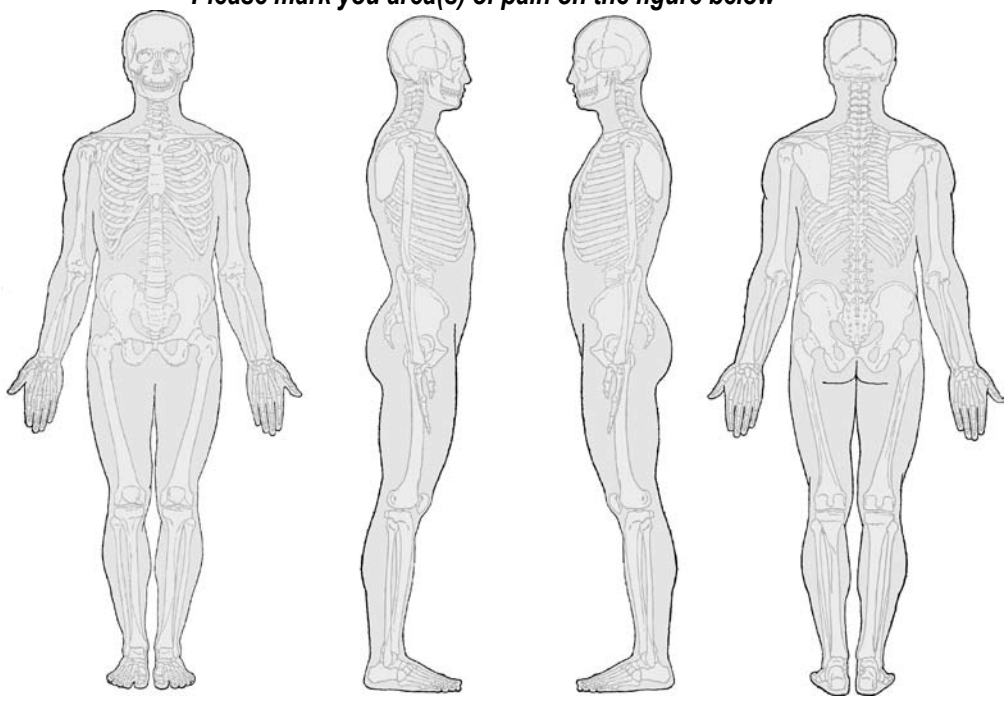
Does it bother you (check appropriate box): □ work, □ sleep, □ other: _____

What seemed to be the initial cause: _____

Please mark you area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:





Past health history

Have you...	Yes	No	If yes, explain briefly
... been hospitalized in the last 5 year?	□	□	_____
... had any broken bones?	□	□	_____
... had any strains/sprains?	□	□	_____
... ever used orthotics?	□	□	_____

How is most of your day spent? □ standing, □ sitting, □ other: _____

How old is your mattress? _____

When was your last physical exam? _____

Habits	none	light	mod.	heavy
Alcohol	□	□	□	□
Coffee	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□
Exercise	□	□	□	□
Sleep	□	□	□	□
Soft drinks	□	□	□	□
Salty foods	□	□	□	□
Water	□	□	□	□
Sugar	□	□	□	□

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

□ Alcoholism _____	□ Cancer _____	□ High blood pressure _____
□ Anemia _____	□ Diabetes _____	□ High cholesterol _____
□ Arteriosclerosis _____	□ Emphysema _____	□ Multiple sclerosis _____
□ Arthritis _____	□ Epilepsy _____	□ Osteoporosis _____
□ Asthma _____	□ Glaucoma _____	□ Stroke _____
□ Bleed easily _____	□ Heart disease _____	□ Thyroid disease _____

Do you have any other health issues or concerns that our staff should be made aware of? _____

_____

Check ☑ and indicate the age when you had any of the following:

General

- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint

- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Skin

- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash

Gastrointestinal

- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary

- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Pus in urine
- ☐ Stress incontinence Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory

- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Eye, Ear, Nose & Throat

- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis
- ☐ Vision problems

Check any of the conditions you have or have had:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Please list any medications (including vitamins and minerals) you are currently taking, dosage and condition:

1 _____ 6 _____

2 _____ 7 _____

3 _____ 8 _____

4 _____ 9 _____

5 _____ 10 _____

Office Use Only:

Effective Date: _____ Is Chiropractic covered? Y / N Is Pre-certification required? Y / N

Individual Deductible: $ _____ APPLIED: $ _____ TO MEET: $ _____

Family Deductible: $ _____ APPLIED: $ _____ TO MEET: $ _____

Co-insurance: _____ % Insurance Percentage of Coverage: _____ % Co-pay: $_____

How many visits allowed: _____Visits Used: _____

Is there a dollar amount limit per VISIT? Y / N AMOUNT$ _____APPLIED: $ _____

Is there a dollar amount limit per YEAR? Y / N AMOUNT$ _____APPLIED: $ _____

INFORMED CONSENT TO CHIROPRACTIC EXAMINATION AND TREATMENT

Do not sign until the chiropractor has discussed the proposed care and material risks with you.

Please read this entire form. You may ask questions, refuse any procedure, or withdraw consent at any time. Signing this form does not waive any legal rights.

1. Nature and Purpose of Chiropractic Care

I voluntarily request evaluation and care from the licensed doctors of chiropractic at Cordova Chiropractic and Wellness. Chiropractic care is provided within the scope of chiropractic practice and does not replace medical services that may be needed from other licensed health-care providers. Referral or co-management may be recommended when appropriate.

2. Procedures That May Be Recommended

Depending on my history, examination findings, diagnosis, preferences, and response to care, the chiropractor may recommend one or more of the following. Not every procedure will be used

- History, physical examination, palpation, posture and movement assessment, range-of-motion testing, orthopedic testing, muscle testing, and neurological screening.
- Chiropractic manipulation or mobilization of spinal and/or extremity joints, performed by hand or with an instrument. Joint movement may produce an audible pop or click, but a sound is not required for treatment to be effective.
- Soft-tissue procedures, including manual therapy, instrument-assisted techniques, and muscle-release techniques.
- Therapeutic exercise or activity, stretching, home-care recommendations, taping, heat, cold, electrical muscle stimulation, and low-level laser or other conservative modalities within the chiropractor's lawful scope of practice.
- Diagnostic imaging, laboratory testing, or referral to another provider when clinically indicated. Any additional procedure requiring separate consent will be explained before it is performed.

3. Expected Benefits and No Guarantee

Possible benefits include reduced pain, improved mobility, improved function, and improved ability to perform daily activities. Results vary. No guarantee or promise has been made regarding the outcome of examination or treatment.

4. Risks and Possible Complications

All health-care procedures involve some risk. The chiropractor has explained the material risks of the care proposed for me. Possible risks include:

- Temporary soreness, stiffness, fatigue, dizziness, headache, bruising, or a temporary increase or change in symptoms.
- Muscle, ligament, joint, rib, or costovertebral sprain or strain; skin irritation or burn from a modality; aggravation of an existing condition; disc injury or aggravation; dislocation; fracture; or nerve injury.
- With treatment involving the neck, rare but serious complications have been reported, including injury or dissection of arteries in the neck, stroke, neurological impairment, paralysis, and death.
- Risks may be increased by conditions such as osteoporosis or weakened bone, bleeding disorders or blood-thinning medication, vascular or connective-tissue disorders, recent trauma, infection, cancer, pregnancy, or other conditions. I agree to disclose known conditions, medications, pregnancy, and meaningful changes in my health.

5. Alternatives and Choice Not to Receive Care

Reasonable alternatives may include no treatment or watchful waiting, self-care and exercise, physical therapy, massage or other conservative care, medical evaluation, prescription or over-the-counter medication, injections, or surgery. Each alternative has its own possible benefits and risks. If I choose not to receive the proposed care, my symptoms may remain unchanged, improve on their own, or worsen.

6. Consent and Acknowledgment

Before signing, I have had the proposed care and its material risks explained to me verbally and in writing in language I understand. I have had the opportunity to ask questions, and my questions have been answered to my satisfaction. I understand that I may refuse any procedure or withdraw my consent at any time. I consent to the examination and treatment proposed by the chiropractor. This consent remains in effect for the current course of care unless I withdraw it. Material changes in the proposed care will be explained, and additional consent may be requested when appropriate.

Date: _____ Date: _____

_____ _____

Patient's Name Doctor's Name

_____ _____

Signatue Signature

_____

Signature of Parent or Guardian (if a minor)

FINANCIAL POLICY AND AUTHORIZATION

Please review this policy before receiving services. Ask us about fees, insurance billing, or payment arrangements before treatment whenever possible.

1. Payment and Statements

Payment for copayments, deductibles, coinsurance, self-pay services, and other known patient-responsibility amounts is due at the time of service unless a written payment arrangement has been approved. Any remaining patient balance is due within 30 days of the statement date.

2. Insurance Billing

As a courtesy, the clinic may submit claims to my health plan when sufficient and accurate information is provided. Verification or quotation of benefits is an estimate and is not a guarantee of payment. I am responsible for keeping my insurance and contact information current and for promptly responding to requests for information needed to process a claim.

3. Patient Financial Responsibility

Subject to applicable law and the clinic's contracts with health plans, I am responsible for deductibles, copayments, coinsurance, non-covered services, services exceeding benefit limits, and out-of-network amounts that may lawfully be billed to me. I am not responsible for contractual adjustments or amounts that a payer agreement or law prohibits the clinic from billing to me.

4. Denied or Delayed Claims

If a claim is delayed or denied, I agree to cooperate with reasonable requests for information or coordination of benefits. When permitted by law and payer rules, amounts may be transferred to patient responsibility after the payer has processed the claim or when the denial results from inaccurate or incomplete information, inactive coverage, lack of a required patient action, or another reason properly assignable to the patient. Provider-side billing errors, contractual write-offs, and other amounts that may not lawfully be passed to the patient will not be billed to me. If I pay an amount that is later paid by insurance, the clinic will apply the payment to my account or issue a refund as

5. Self-Pay Services

If I am not using insurance, or if a service is not billed to insurance, I agree to pay the clinic's current self-pay fee at the time of service. Any discount, package, membership, or special payment arrangement must be separately documented. Uninsured or self-pay patients may request a good-faith estimate of expected charges when applicable.

CORDOVA CHIROPRACTIC AND WELLNESS
FINANCIAL POLICY AND AUTHORIZATION
Continued

6. Authorization to Release Information and Assignment of Benefits
I authorize Cordova Chiropractic and Wellness to release health and billing information reasonably necessary to obtain payment, determine benefits, submit or appeal claims, and coordinate payment with my health plan, third-party administrator, or other responsible payer. I assign to the clinic any insurance benefits payable for services provided to me and authorize direct payment to the clinic. I remain responsible for amounts properly assigned to me under this policy, applicable law, and payer rules.

7. Special Coverage Rules
This financial policy does not replace any notice or agreement specifically required for Medicare, workers' compensation, personal-injury liens, managed-care authorizations, or other payer-specific situations. Additional forms may be required before particular services are provided.

8. Missed Appointments and Other Fees
Any cancellation, no-show, returned-payment, record-copying, or other administrative fee will be disclosed in a separate clinic policy or before the fee is charged. Such fees are generally not billable to insurance.

9. Payment Arrangements and Collections
I may contact the clinic to request a payment arrangement before an account becomes delinquent. If a balance remains unpaid after statements and reasonable collection efforts, the account may be referred to a collection agency. I may be responsible for reasonable collection costs only to the extent permitted by law and any applicable agreement.

10. Acknowledgment
I have read and understand this financial policy. I have had the opportunity to ask questions. I agree to be financially responsible for charges properly assigned to me for services provided to the patient named below. I understand that this agreement does not require me to pay amounts prohibited by law or payer contract.

Date: _____ Date: _____

_____ _____
Patient's Name Doctor's Name

_____ _____
Signatue Signature

_____
Signature of Parent or Guardian (if a minor)