New Patient Intake Form

PATIENT DETAILS

Today's Date	How did you hear about us?			Nickname	
Last Name	First	MI	Sex ☐ Male ☐ Female	Birth Date	Age
Address	Apt#	City	State	Zip	
Cell Phone #	Secondary Phone #		Social Security #		
Appt Reminder Preference ☐ Text ☐ Email ☐ None	Cell Phone Provider		Personal Email		
Married Status ☐ Single ☐ Married ☐ Divorce			Parent Name (for minor patients only)		
Emergency Contact	Relationship		Phone #		
Employer Name			Job Title		

HEALTH HISTORY

What treatment have you already received for your condition?
☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other _____

Have you ever had any imaging procedures for your current condition?
☐ X-rays ☐ CT Scan ☐ MRI ☐ None ☐ Other _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Alcoholism	☐Yes ☐No	Goiter	☐Yes ☐No	Pinched Nerve	☐Yes ☐No
Allergy Shots	☐Yes ☐No	Gonorrhea	☐Yes ☐No	Pneumonia	☐Yes ☐No
Anemia	☐Yes ☐No	Gout	☐Yes ☐No	Polio	☐Yes ☐No
Anorexia	☐Yes ☐No	Heart Disease	☐Yes ☐No	Prostate Problem	☐Yes ☐No
Appendicitis	☐Yes ☐No	Hepatitis	☐Yes ☐No	Prosthesis	☐Yes ☐No
Arthritis	☐Yes ☐No	Hernia	☐Yes ☐No	Psychiatric Care	☐Yes ☐No
Asthma	☐Yes ☐No	Herniated Disk	☐Yes ☐No	Rheumatoid Arthritis	☐Yes ☐No
Bleeding Disorders	☐Yes ☐No	Herpes	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Breast Lump	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
Bronchitis	☐Yes ☐No	High Cholesterol	☐Yes ☐No	Stroke	☐Yes ☐No
Bulimia	☐Yes ☐No	Kidney Disease	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Cancer	☐Yes ☐No	Liver Disease	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Cataracts	☐Yes ☐No	Measles	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	Migraine Headaches	☐Yes ☐No	Tumors, Growths	☐Yes ☐No
Chicken Pox	☐Yes ☐No	Miscarriage	☐Yes ☐No	Typhoid Fever	☐Yes ☐No
Diabetes	☐Yes ☐No	Mononucleosis	☐Yes ☐No	Ulcers	☐Yes ☐No
Emphysema	☐Yes ☐No	Multiple Sclerosis	☐Yes ☐No	Vaginal Infections	☐Yes ☐No
Epilepsy	☐Yes ☐No	Mumps	☐Yes ☐No	Whooping Cough	☐Yes ☐No
Fractures	☐Yes ☐No	Osteoporosis	☐Yes ☐No	AIDS/HIV	☐Yes ☐No
Glaucoma	☐Yes ☐No	Pacemaker	☐Yes ☐No	**Smoker**	☐Yes No
		Parkinson's Disease	☐Yes ☐No	**Other:**	

Signature:_____ Date:_____

HEALTHY LIFE

Consultation Form

Patient Name: _____ **DOB:** _____

Allergies: _____

Primary Medical Provider : _____

Surgical History (please provide dates, if possible)

_____

_____

_____

Present Complaint

Symptoms: _____

When did the symptoms first appear? _____

Have you ever had a problem like this in the past? Yes No

What makes the symptoms worse? _____

What makes the symptoms better? _____

Rate your symptoms on a scale from 0 (least severe) to 10 (most severe): _____

Have you seen another health care provider for this problem? Yes No If yes, who? _____

The symptoms are described as: (circle all that apply)

constant frequent occasional mild moderate severe

sharp burning stiffness swelling locking dull

popping weakness locking buckling achy

Previous treatments: (circle all that apply)

NSAIDs steroid PT topical analgesics HEP brace heat/ice

surgery prescription medication viscosupplementation other _____

Review of Systems

- Any generalized symptoms, such as weakness, fatigue, fever, chills, night sweats, change in sleep pattern, unexplained weight loss/gain or others? YES NO
  If yes, explain: _____
- Any **skin** problems, such as rashes, itching, dryness, sores, changes in skin color, changes in moles, changes in hair, changes in fingernails, or others? YES NO
  If yes, explain: _____
- Any **lung or respiratory** problems, such as cough, shortness of breath, difficulty breathing, congestion, wheezing, coughing up blood, sleep apnea, or others? YES NO
  If yes, explain: _____
- Any **heart** problems, such as a murmur, palpitations, rapid or slow heartrate, chest pain, high/low blood pressure, heart attack, heart failure, valve problems, swelling in the legs, or others? YES NO
  If yes, explain: _____
- Any **gastrointestinal** problems, such as stomach pain, nausea, vomiting, diarrhea, gas/bloating, constipation, rectal bleeding, change in appetite/thirst, change in stools, or others? YES NO
  If yes, explain: _____
- Any **genitourinary** problems, such as painful urination, blood in urine, frequent urination, incontinence, urgency, change in urine appearance, or others? YES NO
  If yes, explain: _____

HEALTHY LIFE

Patient Name: _____ **DOB:** _____

- Any **musculoskeletal** problems, such as muscle pain, muscle weakness, muscle spasm, joint stiffness, joint pain, joint swelling, or joint warmth/inflammation? YES NO
  If yes, explain: _____
- Any **neurological** problems, such as numbness, tingling, weakness, paralysis, dizziness, headache, loss of memory, difficulty sleeping, or stroke? YES NO
  If yes, explain: _____
- Any **psychiatric** problems, such as anxiety, depression, substance abuse/addiction, suicidal thoughts, hallucinations, difficulty sleeping, or others? YES NO
  If yes, explain: _____
- Any **eye, nose, or throat** problems, such as pain, blurred vision, double vision, vision loss, hearing loss, ringing in the ear, vertigo/dizziness, sinus problems, loss of smell, difficulty swallowing, or others? YES NO
  If yes, explain: _____

WOMAC Osteoarthritis Index Pain Scale

Name: _____ Date: _____

Instructions: *Please note the activities in each category according to the following Scale of difficulty:* **0 = None, 1 = Slight, 2 = Moderate, 3 = Very, 4 = Extremely**

Circle **one number** for each activity

Pain

1	Walking	0	1	2	3	4
2	Stair Climbing	0	1	2	3	4
3	Nocturnal	0	1	2	3	4
4	Rest	0	1	2	3	4
5	Weight Bearing	0	1	2	3	4

Stiffness

1	Morning Stiffness	0	1	2	3	4
2	Stiffness occurring later in the day	0	1	2	3	4

Physical Function

1	Descending stairs	0	1	2	3	4
2	Ascending stairs	0	1	2	3	4
3	Rising from sitting	0	1	2	3	4
4	Standing	0	1	2	3	4
5	Bending to floor	0	1	2	3	4
6	Walking on flat surface	0	1	2	3	4
7	Getting in/out of car	0	1	2	3	4
8	Going shopping	0	1	2	3	4
9	Putting on socks	0	1	2	3	4
10	Taking off socks	0	1	2	3	4
11	Lying in bed	0	1	2	3	4
12	Rising from bed	0	1	2	3	4
13	Getting in/out of bath	0	1	2	3	4
14	Sitting	0	1	2	3	4
15	Getting on/off toilet	0	1	2	3	4
16	Heavy domestic duties	0	1	2	3	4
17	Light domestic duties	0	1	2	3	4

Total Score: _____/ 96 = _____%

Bryan S. Aldrich, B.A., D.C.
118 Springhall Drive; Suite B Goose Creek, SC 29445
Phone: 843.735.7115 Fax: 843.735.7114

Informed Consent for Treatment

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable. There may be additional supportive procedures or recommendations as well. If you are here for chiropractic care, know that when providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fractures (broken bones), disc injuries, strokes, dislocations, strains, sprains, infection and death. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic care can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. **The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.**

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

OFFICE FINANCIAL POLICY

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.
2. HEALTHY4LIFE INTEGRATED MEDICINE, Inc. may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.
3. All payments made to the HEALTHY4LIFE INTEGRATED MEDICINE, Inc. for insufficient funds will be charged a $25.00 processing fee regardless of amount. Thereafter acceptable payment will be cash or credit card only.
4. If you have insurance, HEALTHY4LIFE INTEGRATED MEDICINE, Inc. will gladly accept assignment with the following exceptions and regulations, provided we have prior certification from your insurance company.
5. HEALTHY4LIFE INTEGRATED MEDICINE, Inc. accepts assignment for the initial treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment per visit.
6. HEALTHY4LIFE INTEGRATED MEDICINE, Inc. accepts assignment as a courtesy to you; you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.
7. Whenever you receive any worksheets from your insurance company or explanation of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine whether proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue you an overpayment check-it will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.
8. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.

9. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.
10. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payment in full expected immediately; regardless of any claims submitted.
11. If you have questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the Doctor.
12. **Any accounts that become overdue 90 Days or more will be referred to a third party collection agency and a 20% collection fee will be assessed.**

I have read and understand this Financial Office Policy and agree to abide by all terms.

_____ _____

Patient's Signature Date

I understand that I am not personally responsible for the fees associated with the first visit but due to contractual obligations, I understand and agree that all fees associated with my first visit to this office, including but not limited to, exam and all necessary x-rays, will be billed to my insurance company.

_____ _____

Patient's Signature Date

CONSENT FOR TREATMENT AND AUTHORIZATION TO PERFORM X-RAYS

I authorize HEALTHY4LIFE INTEGRATED MEDICINE, INC to perform a radiographic examination if the provider deems necessary to diagnose and to administer whatever examination or treatment is deemed necessary to treat my present problem (or illness).

To the best of my knowledge I am NOT pregnant and the above named clinic has my permission to x-ray me for diagnostic interpretation.

_____ _____

Patient's Signature Date

HIPAA PRIVACY POLICY
CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to/for:

- Carry out treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (i.e. my insurance company)
- The day to day healthcare operation of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at anytime to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at anytime. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____ _____

Patient's Signature Date

AUTHORIZATION, ASSIGNMENT & RELEASE FORM

In consideration of your undertaking of care from HEALTHY4LIFE INTEGRATED MEDICINE, Inc., I agree to the following:

1. HEALTHY4LIFE INTEGRATED MEDICINE, Inc. is authorized to release any information deemed appropriate and necessary concerning my physical condition to any insurance company or adjuster to process any claim for reimbursement of charges I incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney (personal injury cases) , from the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you, based in whole or in part upon the charges made for your services.
3. In the event any insurance company is obligated to make payment to me or to you for the charges made for your services, refuse to make such payment upon demand by you; I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute and take action in my name as you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance companies' proceeds, whether it is all or part of what is due, I personally owe and agree to pay you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in the State of South Carolina.
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization and Assignment will be in continual effort until revoked by both parties.

_____ _____

Patient's Signature DATE