LAKE IN THE HILLS FAMILY CHIROPRACTIC

Adult Intake Form

Date: _____

PERSONAL INFORMATION

First Name: _____ M.I.: _____ Last Name: _____

Preferred Name: _____ Street Address: _____

City I State / Zip:_____

Home Phone:( )_____ Cell Phone:( )_____

Work Phone: ( )_____ Email: _____

Birth Date: _____ Age: _____ Sex: M F

Who can we thank for referring you or how did you hear about our office?

_____

EMERGENCY CONTACT

First Name: _____ Last Name: _____

Preferred Name: _____ Phone:( ) _____

Relation: _____

REASON FOR SEEKING CARE

What is your reason for seeking care at Lake in the Hills Family Chiropractic?

_____

When did this begin? (If applicable)

_____

Are there any major injuries and/or surgeries we should know about?

_____

Have you seen any other providers for this condition? (List all that apply)

_____

Have you seen a chiropractor before? Yes No

How long ago? _____ Clinic/Doctor Name: _____

What is your level of commitment to yourself and your health?

1 2 3 4 5 6 7 8 9 10

LAKE IN THE HILLS FAMILY CHIROPRACTIC

HEALTH CONCERNS

- □ Anxiety/Depression
- □ Digestive Troubles
- □ Nausea/Vomiting
- □ Diabetes
- □ Hypertension
- □ Arthritis
- □ Loss of Balance
- □ Neck/Back Pain
- □ Pain in Arms/Legs
- □ Irritability
- □ Fatigue/Sleep Issues
- □ Dizziness
- □ Ringing in Ears
- □ Sensitivity to Light
- □ Loss of Concentration
- □ Memory Problems
- □ Headaches
- □ Stiffness/Flexibility
- □ Sinus Troubles/Allergies
- □ Cold Hands/Feet

Explain any boxes checked above or add additional concerns:

_____

_____

Is there anything else regarding your current condition you feel the doctor should know?

_____

_____

MEDICATIONS

- □ Anxiety/Depression
- □ Blood Pressure
- □ Pain Narcotics
- □ Muscle Relaxers
- □ Migraine/Headache
- □ Cholesterol
- □ ADD/ADHD
- □ Diabetes
- □ Other

Explain any boxes checked above:

_____

VITAMINS/SUPPLEMENTS

- □ Multi-Vitamin
- □ Vitamin D3
- □ Fish Oil/Omega-3
- □ Probiotics
- □ Other

Explain any boxes checked above:

_____

LAKE IN THE HILLS FAMILY CHIROPRACTIC

FINANCIAL POLICY

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

- We urge our patients to follow the doctor's recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, your care plan must be followed.
- A $25 fee will be charged to your account for any appointments missed without a 24-hour notice of cancellation. We require a credit or debit card on file due to this policy.
- Balances accrued for non-coverage, deductible and/or co-payment amounts greater than 120 days outstanding will be charged to the card on file at the end of the business day on the 121st day. We require a credit or debit card on file due to this policy.
- I authorize Lake in the Hills Family Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me.
- In order to file your claims in a timely manner (if applicable), we need current, accurate insurance information for you and your dependents. We will do our best to confirm your eligibility and level of insurance coverage for care; however, it is ultimately your responsibility to know your own insurance benefits. Should your insurance carrier determine that any or all our services are ineligible for payment, you will be billed directly for those services.
- This office will prepare any necessary reports and forms to assist me in making collection from the insurance company. Any amount authorized to be paid directly to this office will be credited to my account. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.
- Late payment for non-coverage, deductible, and co-payment will be subject to an 18% annual finance charge, which will be added monthly to your account.
- If you have any questions about our financial policies, please speak with our staff. If you need to make special payment arrangements, we will do everything possible to meet your financial needs.

Patient Signature: _____ Date: _____

CONSENT TO CHIROPRACTIC SERVICES

I hereby request and consent to chiropractic adjustments and other procedures (therapeutic treatment, if necessary), by Dr. Elizabeth Eyles and her staff who now or in the future treat me while employed by this office. I will have an opportunity to discuss with Lake in the Hills Family Chiropractic personnel the nature and purpose of treatment indicated. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. I do not expect the Doctor to be able to anticipate and explain all risks and complications and wish to rely on the Doctor to exercise judgment during the course of any procedure which the Doctor feels at the time is in my best interest. I understand that Lake in the Hills Family Chiropractic will not be held responsible for any pre-existing medical conditions. I certify that the information contained in my health history is correct to the best of my knowledge. I will not hold my doctor or any staff member of Lake in the Hills Family Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future care provided by this clinic and/or employed staff.

Patient Signature: _____ Date: _____

LAKE IN THE HILLS FAMILY CHIROPRACTIC

CONSENT TO USE PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by LAKE IN THE HILLS FAMILY CHIROPRACTIC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. **_____Patient Initials**

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

X-RAY CONSENT FOR WOMEN OF CHILDBEARING AGE

X-ray examination of the abdomen and pelvis expose the uterus to radiation. The last ten days following onset of the menstrual cycle are generally considered safe for x-ray examination.

Date of onset of last menstrual period: _____ I am pregnant: Yes No

I had a hysterectomy: Yes No I use an IUD: Yes No

I recognize that if I am pregnant and have radiation to the abdomen, there is a possibility of injury to the fetus. However, I understand that the likelihood of such injury is slight and that my physician feels that the information to be gained from this examination is important to my health. I therefore wish to have this x-ray examination performed now.

Patient Signature: _____ Date: _____