Charge Into Health Family Chiropractic

Practice Member Information

PLEASE PRINT

Full Name _____ DATE _____

Address: _____ City _____ State _____ Zip _____

Cell Phone Number: _____

May we text you if the office will be closed or with other special bulletins? □ Yes □ No

Email Address: _____ ___

May we email you our monthly newsletter, important updates, schedule changes, etc. □ Yes □ No

Date of Birth: _____ (MM/DD/YYYY) Age: _____ □ Male □ Female Height _____ Weight _____

Status: □ Single □ Married □ Divorced □ Widowed No. of Children?: _____

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

What have you heard about chiropractic? _____

Have you been to a chiropractor before? □ Yes □ No If yes… Was it a good experience? □ Yes □ No

Who and when? _____ Reason for discontinuing care? _____

Health History

What is your reason for visiting this office? _____

_____

How has this affected your life? _____

_____

Have you seen any other doctor(s) about this? □ Yes □ No If yes…

Treatment Received: _____ Outcome: _____

Medical History (Please include all health conditions for which you have been treated and/or suffer from)

_____

_____

Have you **EVER** had any Surgeries/Hospitalizations? □ Yes □ No If yes…

Type: _____ When: _____

Type: _____ When: _____

Have you **EVER** had any Traumas/Falls/Accidents? □ Yes □ No If yes…

Type: _____ When: _____

Type: _____ When: _____

Do you take **ANY** Drugs/Medications/Supplements? □ Yes □ No If yes, list: _____

_____

Health/Lifestyle

Stress (Please rate from 1 Pure Bliss to 10 Nervous Breakdown): Work _____ Personal Life _____ Health _____

□ Alcohol: _____ Drinks per week □ Smoking: _____ packs per week

□ Coffee: _____ Drinks per week □ Other Chemical Dependencies: _____

Exercise? _____ Hobbies? _____

Sleep Issues? □ Yes □ No Please describe (deep/restful, interrupted, etc.): _____

Do you sleep on your… □ Back □ Side □ Stomach

WORK INJURY AND AUTOMOBILE INJURY NOTICE

By signing below, I acknowledge that I am aware that Charge Into Health Family Chiropractic and John W. Blalock, DC do not provide care for work related injuries, automobile accident injuries, or personal injury of any kind***. I also acknowledge that I must inform this office if I am in an automobile accident or have a work related injury and must seek care at a medical doctor's office or another healthcare provider for any injuries or conditions sustained in the above mentioned manners.***

I am also completely aware that ***Charge Into Health Family Chiropractic and Dr. John W. Blalock will not bill, submit claims, nor prepare or submit reports for any automobile, personal, or work related injury.*** I also understand that I am responsible to pay each visit myself at the time of service.

CONSENT TO INITIATE CARE

At our office we have a simple goal – we want to provide the highest quality CHIROPRACTIC care at the most affordable cost to the patient. In order to accomplish this goal, we have altered some of our business procedures to keep our fees reduced. Please read over these procedures below to understand how our office functions and to decide if you wish to participate. If you have any questions, please ask us!

- You may choose to submit receipts to your insurance company or other third-party health care programs, but payment for such services by insurance companies is neither implied nor agreed to by this office. We take ***NO RESPONSIBILITY*** for non-payment by insurance companies for services rendered in our office
- Our office will **NOT** respond to any requests for paperwork for insurance purposes or even acknowledge insurance requests for information on any patient's case. However, patients may have a copy of their records at any time they request.
- **NO** balances can be kept or run by patients at any time.
- All adjustment visits are paid immediately ***upon completion*** of the service being rendered.
- Initial exam and 1st adjustment are paid ***upon completion*** of these services.
- Our office reserves the right to deny services to anyone for any reason or if the Doctor feels that the patient's health is not being best served.

I wish to initiate care at this office. I have read and understand the ***Work Injury and Automobile Injury Notice*** and the ***Consent to Initiate Care*** and agree to all terms. I understand that I am under no obligation to receive or continue care.

Signature: _____ Date: _____
(Parent or Guardian if under 18 years of age)

PATIENT AUTHORIZATION
Open Adjusting Environment & Sign-In Sheets

Our office uses sign in sheets and provides care in an "open" adjusting environment. Adjustments are provided in an open adjusting area. As a result patients are in sight of each other and some ongoing routine details of care may be within earshot of other patients and/or staff. This environment is used for ongoing care and is not the environment for taking patient's histories, performing examinations or presenting report of findings. These procedures are done in a private, confidential setting. Your signature below indicates your authorization for this activity. In addition your signature below authorizes us to contact you at all the phone numbers/addresses you list on this intake form. If you do not wish to be contacted at any listed numbers/address, please let us know.

Signature: _____ Date: _____
(Parent or Guardian if under 18 years of age)

Personal Medical Information Consent Form

The Health Insurance Portability Accountability Act of 1996 (HIPAA) requires that we receive your permission before we use the personal information in your medical records for any reason. This consent form gives us permission to use your Protected Health Information (PHI) to carry out treatment **ONLY**! You have the right to revoke, in writing, this consent form at the time, although any services performed prior to the revocation of this consent are covered by this consent.

Signature: _____ Date: _____
(Parent or Guardian if under 18 years of age)
