Office Use: __Demo __Scan __Ins __Phys __Note

New Patient Intake

DIRECTIONS : *fill out completely; there are multiple pages*

Name: ________________________________ Today's Date: ___ /___/___

Date of Birth:___/___/______ Social Security Number: ________-______-________

Address:____

City:_______________________ State:__________ Zip Code:_________________

Cell #:____________________ Email ______________________________

Occupation ______________________________ Employer ________________________

Single/ Married / Divorced / Widowed: Spouse's Name: ____________________ # of Children: ____

How did you hear about us? __________________________

What brings you into the office today?____

Insurance Information

Insurance company:____________________________________ Phone #__________________

Address:____

City /State/Zip:____

Insured's Name:____________________ Insured's SSN:__________ Group#______________

Insured's Birth Date:____________________ Insured's Employer:_______________________

Major Complaint Information

Complaint #1: __________________________ When did it start? ____ days ago ____ weeks ago ____ months ago ____ years ago; What does it feel like? dull, ache, sharp, shooting, stabbing, throbbing, stiffness or other ____________; It's better with: sitting standing stretching walking lying down; It's worse with: sitting standing stretching walking lying down; On average my pain is a (scale of 1-10 with 10 being the worst pain imaginable) 1 2 3 4 5 6 7 8 9 10; Timing of the pain: constant or on/off
Anything else to add? ____

Complaint #2: ______________________________ When did it start? ____ days ago ____ weeks ago ____ months ago ____ years ago; What does it feel like? dull, ache, sharp, shooting, stabbing, throbbing, stiffness or other ____________; It's better with: sitting standing stretching walking lying down; It's worse with: sitting standing stretching walking lying down; On average my pain is a (scale of 1-10 with 10 being the worst pain imaginable) 1 2 3 4 5 6 7 8 9 10; Timing of the pain: constant or on/off
Anything else to add? ____

My pain/complaints interferes with my (Check all that apply): __ sleep __work __ workouts__moods ___ability to lift ___ time with kids ___ focus___other: ____

What treatment have you already received for your condition? __Chiropractic ___Medication ___Surgery__Physical___Therapy___None___Other:____

2021 Health Goals: ____

Rate your Commitment to Feeling Better (scale of 1-10; 10 is most committed) 1 2 3 4 5 6 7 8 9 10

Name of your primary care doctor ____

Date of Last: Physical Exam_____________ Spinal X-Ray____________ Blood Test_____________

Spinal Exam___________ Dental Exam_____________ MRI, CT-Scan, Bone Scan________________

Are you Pregnant? ______ No _______ Yes Due Date: _______________________

Falls/Head Injuries ____

Broken Bones/Dislocations____

Surgeries____

CIRCLE ANY AND ALL OF THESE PROBLEMS YOU'VE HAD IN THE LAST YEAR

Migraine	Herniated Disk	Lupus	Pinched Nerve	Arm Pain
Headache	Dizziness	Nausea	Kidney Problems	GERD
Sciatica	Ulcers	Bladder Problems	TMJ	Gout
Arthritis	Vertigo	Chest Pains	Irritable Bladder	Sciatica
Fibromyalgia	Ear Infections	Arm Numbness	ADD/ADHD	Neck Pain
Leg Numbness	Hand Numbness	Feet Numbness	Anxiety	Infertility
Shoulder Pain	Low Back Pain	Nervousness	Heart Disorders	Hip Pain
Epilepsy	Neck Stiffness	Mid back Pain	Leg Pain	Chronic fatigue
Chronic Sinus	Stomach Issues	Knee Pain	Throat Issues	Hernia
Liver Disease	AIDS/HIV	Alcoholism	Anemia	Anorexia
Appendicitis	Blood Disorder	Breast Lump	Bronchitis	Bulimia
Cancer	Diabetes	Glaucoma	Heart Disease	Hepatitis
Chemical Dependency	Liver Disease	Mononucleosis	High Cholesterol	Mumps
Multiple Sclerosis	Pneumonia	Tonsillitis	Tumors, Growths	Tuberculosis
Psychiatric Care	Pacemaker	Prostate Problems	Stroke	Thyroid Problem

Social History

Exercise: Days per Week _____; Type of Workouts: HIIT Weights Yoga Other: ___________

Work: Average # of hours you sit at work ____; Average hours you stand at work ____.

Habits: Do you smoke? Y N How many packs/day?___; Do you drink alcohol? Y N Drks/wk ___

What's your Diet Like ____

Medications	Allergies	Vitamins/Herbs/Minerals

Informed Consent

When a patient seeks chiropractic health care with our facility and we accept a patient for such care, it is essential for both to be working for the same objective as a team to help you in attempting to reach your health goals. This will prevent any confusion or disappointment on either end. We are **very successful** in helping a variety of conditions because our patients are held to a certain standard. If you are not compliant with doctor recommended care we reserve the right to dismiss your case and refer you elsewhere immediately. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo our unique chiropractic/rehab/medical protocols after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. **Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.** An adjustment is the specific application of force to correct and/or reduce vertebral subluxation (misalignment that alters physiology). Our chiropractic method of correction is by specific adjustments of the spine and physical rehab. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider. All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

____ ____________________

Patient Signature **Date**

Minor Consent for Evaluation and Treatment (under 18)

I, _________________________, the parent or legal guardian of _________________________, have read and fully understand the above Informed Consent and hereby grant permission f or my child to receive chiropractic care. I also consent to Dr. Pero treating my child if legal guardian is not present.

______________________________________ __________________

Signature Date

Insurance and Appointment Policy

No-shows, Cancellations, and Rescheduling

We reserve the right to charge a $25 missed appointment fee for **no-shows or cancellations** with less than **24 hours** notice.

Assignment of Benefits

I hereby assign all medical/chiropractic benefits, to include major medical benefits, personal injury payments, medpay payments, to which I am entitled to JP Chiropractic. I hereby authorize and direct my insurance carrier(s), private insurance and any other health/medical plan, to issue payment check(s) **directly to JP Chiropractic** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Our office policy states that payment is due when services are rendered. We attempt to collect all copays and allowables up front to prevent billing confusion post treatment.

- Cash/ Check/ Credit Card: Payment is due in full when services are rendered. We accept Visa, Master Card, American Express, and Discover cards for payment.
- Insurance: We will file your medical insurance for you. We must have a copy of your health insurance card as well as your driver's license for your file. Deductible amounts and co-payment amounts are due in full as services are rendered. We will balance bill if we under or overcharge based on your agreement with your insurance company. Any charges not covered by the insurance company will be billed directly to you for payment.
- Personal Injury- medpay or a letter of protections and/or lien is necessary
- Medicare: We must have a copy of your Medicare card for verification of coverage.

I have requested medical services from JP Chiropractic on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

____ _____________________

Patient/Responsible Party Signature **Date**

____

Print Name

Pregnancy Release (Females)

If recommended for further x-ray testing this is to certify that to the best of my knowledge I am ***not*** pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _________________________

_________________________________ __________________

Signature Date

Privacy Practices

In this document, "I" and "my" refer to the patient, and "Chiropractor" refers to JP Chiropractic.

I consent to the use or disclosure of my protected health information to the Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct healthcare operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by the Chiropractor may be conditioned upon my consent a s evidenced by my signature below. I also consent to receiving correspondence from JPC in the form of text, social or otherwise.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. If Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I reserve the right to request a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right to review the Notice of Privacy Practices before signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of m y bills or in the performance of healthcare operations of the Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at 1001 Physicians

Drive, Charleston, SC 29414. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

The Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of the Chiropractor and requesting a revised copy to be sent by mail or asking for one at the time of my next appointment.

____ ________________

Signature of Patient or Personal Representative **Date**

____

Print Name