WELLS CHIROPRACTIC

Patient Intake Please provide the following information. If you have any questions or need assistance please contact our staff.

Last Name	First Name	M.I.
Nickname		Date of first appointment
Address		
City	State	Zip Code
Cell Phone	Work Phone	Home Phone

Patient Personal Information

Email	DOB	Age	☐ Male ☐ Female
Patient Employer	Social Security #		
Address			
City	State	Zip Code	
Spouse or Guardian Name	Marital Status ☐ Single ☐ Married ☐ Other		
Cell Phone	Work Phone	Home Phone	
Employer Name			

Emergency Contact

Name (other than spouse)		Relationship to Patient
Cell Phone	Work Phone	Home Phone

Financial Responsibility

Person Responsible for Account ☐ Self ☐ Spouse ☐ Parent ☐ Other		Social Security #
☐ **I have insurance and will complete the following** ☐ **N/A - I will be paying out of pocket**		
Primary Policy Holder's Name	Telephone	DOB
Primary Insurance Company	Policy ID #	Group #
Secondary Coverage for Account ☐ Self ☐ Spouse ☐ Parent ☐ Other ☐ NONE		DOB
Secondary Policy Holder's Name (complete if not provided above)		Telephone
Secondary Insurance Company	Policy ID #	Group #

Are you here because you were involved in a motor vehicle collision? ☐ Yes ☐ No

Are you here because you were injured at your place of employment? ☐ Yes ☐ No

Are you here because you were involved in another type of accident? ☐ Yes ☐ No

Will you be using health insurance to supplement payment at our office? ☐ Yes ☐ No

How did you hear about Wells Chiropractic?

☐ Internet ☐ Social Media ☐ Referred by: _____

☐ Other (Please Specify) _____

X _____ I *attest to the best of my knowledge, the above information is accurate and true.*

Disclosure

We are here to provide services to our patients the best way we know how. We understand the value of health insurance to our patients. However, because health insurance plans are intended only to supplement out of pocket expenses for your care, your insurance may not cover all the care you need. Our staff will verify your insurance benefits individually and report this supplemental coverage to you.

Our relationship is with each patient individually and not with the insurance companies. Therefore, following your initial examination, should we determine that you are a candidate for treatment in our office, we will recommend a treatment plan that is designed specifically for you. It is our intention to be able to provide care for our patients that is affordable regardless of health insurance coverage.

I understand and agree to the following:

- There is no guarantee that my health insurance plan or policy will pay for all or part of my care
- I will be informed of the fees and charges by the staff before these services are performed
- As a patient or guardian of the patient, I am ultimately responsible for all charges incurred during services rendered as a result of care in this office
- A thorough health history, clinical examination and pertinent diagnostic testing will be performed today by the doctor to evaluate

_____

Patient/Guardian Signature ***Date***

Health Complaints

What is your primary complaint?
How long have you been experiencing this primary complaint?
Has this progressed over time?

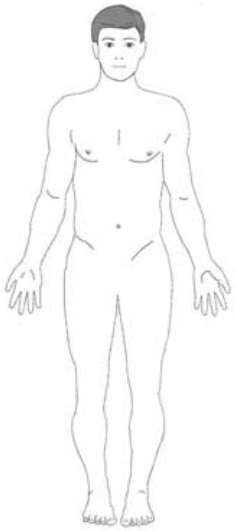
Using the scale below, rate how your primary complaint affects your life by circling one number:

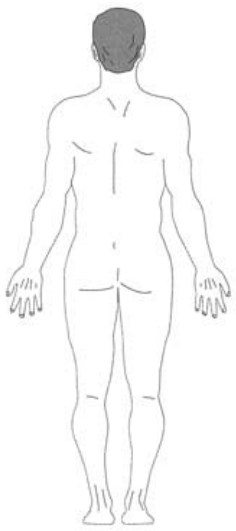
1	2	3	4	5	6	7	8	9	10
Symptoms that do not effect life in any way	Symptoms that slightly effect life	Symptoms that don't effect daily activity	Symptoms that affect daily activities	Symptoms that prevent performing daily activities	Symptoms that limit work schedule	Symptoms that prevent work attendance	Symptoms that prevent work and all personal activity	Symptoms that keep me from leaving home	Symptoms that cause thoughts of suicide

Do you have any additional symptoms (musculoskeletal, neurological or otherwise) that relate to this? Please list below:
Please list any other health conditions/complaints you are currently experiencing:
1)_____ 2) _____
3)_____ 4) _____

Please use the images on the right to mark the areas affected by your primary complaint and any of the associated symptoms listed above.

Include any additional descriptions or comments concerning your health complaints if necessary.





Medical History

Mark any of the following conditions as they pertain to you:

☐ Anemia	☐ Diabetes	☐ Mumps	☐ Tuberculosis
☐ Appendicitis	☐ Epilepsy	☐ Pleurisy	☐ Venereal Infection

☐ Arthritis	☐ Hypertension	☐ Pneumonia	☐ Whooping Cough
☐ Asthma	☐ High Cholesterol	☐ Psychiatric Disorders	☐ A
☐ Blood Disorders	☐ HIV Positive	☐ Rheumatic Fever	☐ B
☐ Cancer	☐ Measles	☐ Seizure Disorder	☐ C

Any cardiac conditions? ☐ No ☐ Yes (please explain)

Any significant illnesses or infections in your past? ☐ No ☐ Yes (please explain)

Any recent illnesses or infections? ☐ No ☐ Yes (please explain)

Any known allergies or sensitivities? ☐ No ☐ Yes (please explain)

Any autoimmune conditions?(thyroid disorders, eczema, psoriasis, RA, Lupus, etc.) ☐ No ☐ Yes (please explain)

List any broken bones or dislocations you have had (include locations, R/L) ☐ No ☐ Yes (please explain)

Have you suffered any head injuries (including concussions)? ☐ No ☐ Yes (please explain)

Were you ever knocked unconscious? ☐ No ☐ Yes (please explain)

Have you ever had a lapse in memory? ☐ No ☐ Yes (please explain)

Have you ever had a spinal tap or injection? ☐ No ☐ Yes (please explain)

Surgical History

Do you have any implantable medical devices in your body? (including pacemakers, stents, plates, screws)
☐ No ☐ Yes (please explain)

Mark all of the following procedures as they pertain to you: *(for procedures listed in 3rd column, please describe on adjacent line)*

☐ Tonsillectomy	☐ Thyroid surgery	☐ Neurosurgery	
☐ Gall bladder removal	☐ Stomach surgery	☐ Spinal surgery	
☐ Appendectomy	☐ Rectal surgery	☐ Cardiac surgery	
☐ Hernia Repair	☐ Abdominal surgery	☐ Orthopedic surgery	
☐ Breast implant surgery	☐ Tubes in ears	☐ Female surgery	
☐ Cesarean Section	☐ Knee/hip replacement	☐ Male surgery	

Review of Systems *Mark any of the following **conditions/symptoms that currently** pertain to you:*

General

☐ Consistent fainting	☐ Chills	☐ Convulsions	☐ Depression	☐ Dizziness
☐ Loss of weight	☐ Fatigue	☐ Fever	☐ Headaches	☐ Loss of sleep

☐ Weight gain	☐ Neuralgia	☐ Night sweats	☐ Wheezing	☐ Nervousness

Gastro-Intestinal

☐ Constipation	☐ Diarrhea	☐ Gall bladder issues	☐ Hemorrhoids	☐ Poor Digestion
☐ Liver problems	☐ Nausea	☐ Stomach pain	☐ Poor appetite	☐ Changes in urgency
☐ Rectal bleeding	☐ Vomiting	☐ Vomiting blood	☐ Jaundice	☐ Changes in frequency

Eye/Ear/Nose/Throat

☐ Asthma	☐ Sore Throat	☐ Tonsillitis	☐ Blurry vision	☐ Earache
☐ Ear Noises (tinnitus)	☐ Enlarged thyroid	☐ Crossed eyes	☐ Double vision	☐ Ear discharge
☐ Nasal obstruction	☐ Nose bleeds	☐ Worsening vision	☐ Eye pain	☐ Deafness
☐ Hay fever	☐ Sinusitis	☐ Hoarseness	☐ Changes in sense of smell	☐ Changes in sense of taste

Respiratory

☐ Chronic cough	☐ Chest pain	☐ Difficulty taking normal breath	☐ Difficulty taking deep breath	☐ Wheezing
☐ Heaviness in chest	☐ Coughing blood	☐ Coughing phlegm		

Musculoskeletal

☐ Backache	☐ Foot pain	☐ Pain between shoulder-blades	☐ Painful tailbone	☐ Neck stiffness
☐ Spinal curvature	☐ Loss of range of motion	☐ Weakness	☐ Changes in muscle tone	☐ Muscle twitching
☐ Muscle tremors	☐ Swollen joints	☐ Changes in gait		

Cardio-Vascular

☐ Ankle swelling	☐ Poor circulation	☐ High blood pressure	☐ Low blood pressure	☐ Heart fluttering /palpitations
☐ Rapid Heartbeat	☐ Slow heartbeat	☐ Pain over heart	☐ Venous insufficiency	

Skin

☐ Dryness	☐ Bruise easily	☐ Hives	☐ Itching	☐ Eczema
☐ Sensitive skin	☐ Skin discolorations	☐ Thinning of skin		

Neurological

☐ Attention problems	☐ Mental fogginess	☐ Mental fatigue	☐ Mood change	☐ Lack of motivation
☐ Uncoordination	☐ Difficulty with word retrieval	☐ Difficulty remembering names	☐ Difficulty remembering faces	☐ Difficulty expressing feelings
☐ Difficulty recalling memories	☐ Difficulty understanding directions	☐ Difficulty with simple math calculation	☐ Difficulty with comprehension	☐ Difficulty finishing tasks
☐ Abnormal sensations	☐ Uncontrollable movements	☐ Increased anxiety or panic	☐ Increased sensitivity to light	☐ Increased sensitivity to Touch
☐ Increased sensitivity to sound	☐ Easily get annoyed/frustrated			

Injuries - *Please write N/A if you have NOT been involved in a particular accident.*

*List any **(even minor) motor vehicle collisions** (auto or otherwise), that you have been involved in as either a driver or a passenger, begin with the most recent:*

Type of collision	Injuries suffered & treatment received	Date of injury

*List any **job injuries** that you have experienced below. Begin with the most recent:*

Type of injury	Treatment received	Date of injury

*List any **athletic injuries** that you have experienced below. Begin with the most recent:*

Type of injury	Treatment received	Date of injury

*List any **other** injuries that you have experienced below. Begin with the most recent:*

Type of injury	Treatment received	Date of injury

Lifestyle & Nutritional Habits

Do you work? ☐ Yes ☐ No, unemployed ☐ Disability ☐ Retired
Occupation (if working or previously)
On average, how many hours of television do you watch per day? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ >5
On average, how many hours per day do you use a computer work/home? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ >5
On average, how many hours per day do you ride in a car or other vehicle? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ >5
Do you exercise? ☐ Yes ☐ No - *If yes, how often* ☐ Daily ☐ 3-5x/wk ☐ 2x/wk ☐ 1x/wk
On average, how long do your workouts last? ☐ >1hr ☐ 1 hr ☐ 30 min ☐ <30 min

What are your exercise activities:

☐ Walking ☐ Swimming ☐ Weight lifting

☐ Yoga/Pilates ☐ Stretching/Flexibility ☐ Resistance Bands

☐ Running/elliptical/rowing/stair climbing ☐ Group Exercise Class ☐ Other _____

Do you smoke tobacco? ☐ Yes ☐ No *- If yes, how often* *-how much*

Do you use recreational drugs? ☐ Yes ☐ No

How many servings of alcohol do you drink per week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

How many servings of coffee do you drink per week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

How many servings of soda do you drink per week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

What does your diet primarily include (please mark all that apply)

☐ Breads, cereals
☐ Pastas, rice
☐ Cookies, crackers, pretzels
☐ Lean protein
☐ Dairy (milk, cheese, ice cream)
☐ Vegetables
☐ Processed meats (lunch meat, etc.)
☐ Fruit
☐ Candy
☐ Processed/packaged snacks/meals
☐ Soda/energy & sugary drinks
☐ Coffee/tea
☐ Water

What is your attitude about food/eating? (please mark all that apply)

☐ Eat 3 full meals per day
☐ Eat less than 3 full meals per day
☐ Snack often throughout the day
☐ Eat balanced meals
☐ Do not eat balanced meals
☐ Very picky about foods
☐ Overeat at each meal
☐ Am hungry soon after each meal
☐ Prefer snacking over meals
☐ Enjoy eating
☐ Poor appetite for food in general

Family Health History

Mark the following conditions as they pertain to your family OR write N/A if they do not apply. Include family member ***(parents, siblings, children, grandparents)***

Diabetes		Cancer	
Heart problems		Vascular problems (including stroke, embolism)	
Kidney problems		Muscle diseases (myopathies)	
Gastrointestinal problems		Nerve diseases (neuropathies)	
Autoimmune conditions		Neurological conditions	
Respiratory conditions		Psychiatric conditions (depression, bipolar, schizophrenia, etc.)	
Musculoskeletal conditions		Headaches	
Other			

Does any member of your family have a condition/symptom(s) similar to yours? ☐ Yes ☐ No
If yes, please explain:

Please list medications that you are on or N/A if NONE:

Medication Name	Dosage	Times per day/week

Print Patient First & Last Name

HIPPA Notification

Please note any additional comments or concerns you would like us to know regarding your health:

It is my responsibility to complete the clinic's forms accurately and provide the most up to date information.

It is my responsibility to notify the doctor if any of the information has changed or requires updating.

Patient/Guardian Signature ***Date***

We at Wells Chiropractic want you to know how your Patient Health Information (PHI) will be used in this office and what your rights are concerning those records. Before we will begin any health care operations **we require you to read and sign** this consent form stating that you understand and agree with how your records will be used. If you would like more details please request a HIPPA PRIVACY NOTICE available at the front desk, before signing this consent.

1. The patient understands and agrees to allow Wells Chiropractic to use their PHI for the purpose of treatment, payment, healthcare operations and coordination of care. Our office will limit the release of all PHI to the minimum needed for correspondence with other healthcare providers and insurance companies.

2. The patient has the right to examine and obtain a copy of his/her own health records at any time. The patient may request corrections and to know what disclosures have been made and may submit, in writing, any further restrictions on the use of their PHI. However, changes and restrictions made and agreed to by us must be within the scope of state and Federal laws.

3. The patient's written consent need only be obtained one time for all subsequent care given at Wells Chiropractic.

4. The patient may provide a written request to revoke consent at any time during their care. Please note: this request would only apply to records from the date of the request forward, and does not include use of records prior to the request.

5. Wells Chiropractic may contact you periodically regarding appointments, treatments, products, services, payment or charitable work performed. You have the right to "Opt-out" of any marketing or fundraising communications at any time.

6. Wells Chiropractic enforces the "right to privacy". All our staff is trained in handling patient records and enforcing privacy. Your records are not readily available to those that do not need them.

7. The patient has a right to file a formal complaint with the Secretary of HHS about any possible violations of these policies and procedures, without retaliation by Wells Chiropractic.

8. Wells Chiropractic reserves the right to make changes to this notice and make new notice provisions effective for all protected health information that it maintains. If changes are made, you will be provided with the new notice.

9. Refusal to sign this consent may result in Wells Chiropractic's right to refuse care.

I (Patient/Guardian Name), _____ have read and understand how my Patient Health Information (PHI) will be used and agree to the above policies and procedures.

_____

Patient/Guardian Signature ***Date***

Electronic Mail (email)/Text Communication Agreement

Please read and initial each line below:

X _____ Wells Chiropractic offers our patients the ability to communicate with us via Electronic Mail (email) and SMS Text. However, Email and SMS Text is not always the most secure and confidential way of communicating. This being said, due to HIPPA regulations, we need the consent of our patients before we are able to send or receive any emails/text messages including but not limited to; chart notes, ledgers, appointments, intake and history information, X-ray lab results, etc…

X _____ Responses and replies to email/text communications that are sent or received by either patient

or Wells Chiropractic may be hours or days apart. As such, acute conditions should never be addressed via email/text.

X _____ Wells Chiropractic doctors and staff will make every effort to maintain privacy when using email/text communications. In some cases, it may be necessary for staff to receive and process these types of communications. I understand this and agree to use email/text communication as a means of confidential communication.

Patient Request for Email and/or Text Communication

Please complete the information below and initial each X if you wish to communicate via email and/or text.

X _____ The email address and/or cell phone number contained herein is accurate, and I accept full responsibility for messages sent to or from this email and/or phone number.

X _____ I understand and acknowledge that there are inherent privacy risks when communicating via internet or unsecured phone lines.

X _____ I agree to hold Wells Chiropractic and its agents and representatives harmless from any and all claims and liabilities arising from or related to this Patient Request for email and/or text Communications.

☐ Patient does NOT consent to email communications ☐ Patient does NOT consent to text communications

_____

Patient/Guardian Signature ***Date***

Informed Consent For Chiropractic Treatment

Please review the guidelines, complete or mark N/A and sign. If you have any questions, please contact the staff.

I (patient/guardian) _____, authorize Chiropractic Care, including spinal adjustment, of me or my minor child by the Doctors of Chiropractic at Wells Chiropractic.

Chiropractic care, like all forms of healthcare, while offering considerable benefit may also provide some level of risk. This level of risk is most often minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care at this office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

_____
Print Patient First & Last Name

Policy on Patient Accounts

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall wellbeing. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications and procedures given for the same symptoms.

Prior Chiropractic Treatment Information

Name of Chiropractor _____ Location (City) _____

When was your last treatment _____ Have you had X-Rays taken? _____

Medical Doctor Wells Chiropractic believes your medical doctor is a vital part of your healthcare team. As such, upon your request, we may send evaluations and progress reports to the physician listed below:

Name of Doctor _____ Specialty _____

Address _____

City _____ State _____ Zip Code _____

By signing below, I state that I have been informed and weighed the risks involved in chiropractic procedures at this health care clinic. I have decided, freely and voluntarily, that it is in my best interest to receive chiropractic care. I give my consent to that treatment. This consent will cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

_____

Patient/Guardian Signature ***Date***

Please review the following guidelines and initial EVERY X. If you have any questions, please contact the staff.

X_____ 1. **CANCELLATION AND/OR NO-SHOW** Wells Chiropractic urges you to keep every appointment, as consistent treatment provides optimal benefit. As a courtesy, we send out email/text message reminders to help you keep your appointment. In the event that you are unable to keep a scheduled appointment we require at least 24 hours' notice, excluding Sunday. Patients who cancel without proper notice or fail to show for a scheduled appointment will be subject to a NO-SHOW charge of $50 for new patients and $35 for established patients (for each missed appointment).

If you arrival more than 15 minutes late your appointment may be considered a NO-SHOW appointment and may result in the need to reschedule and you may incur the NO-SHOW charge mentioned above. For established patients we allow for 2 grace NO SHOW appointments and will begin charging after the 2nd occurrence. If this is necessary, we will track these dates below and notify you.

(office use only)

#1 NO-SHOW date _____ #2 NO-SHOW date _____

X_____ 2. **COST OF SERVICE(S)** The cost of service(s) rendered varies based on the extent, focus and testing required at your visit. Some of the services or supplies offered or suggested by this office may be considered non-covered items under your insurance plan; you are responsible for these services and/or supplies at the time of service. A fee schedule is available at the front desk.

X_____ 3. **FINANCIAL/INSURANCE RESPONSIBILITY** Wells Chiropractic staff will bill your insurance carrier as a courtesy to you. Your insurance contract is an agreement between you and your insurance company. As the subscriber member you are responsible for the terms of that agreement. Your insurance should make payments directly to this office. The member is responsible for any deductibles, co-payments, co-insurance and/or other patient balances not covered by insurance.

Payment is required at or before each visit. I am responsible for covered and excluded items not paid for by my insurance carrier or other party responsible for coverage of my medical expenses. I agree that I am responsible for any payments for services my insurance carrier determines, either now or at a later date, to be unreasonable or not medically necessary. I further understand that Wells Chiropractic will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Wells Chiropractic to take action to secure payment of an outstanding balance owed.

X_____ 4. **ASSIGNMENT OF BENEFITS** I authorize payment of my Medicare and/or insurance benefits to be made directly to Wells Chiropractic on my behalf for services rendered. In the event that my insurance does not accept Assignment of Benefits, or if payments are made directly to me, I will endorse such payments to Wells Chiropractic within five (5) days of receipt of payment.

X_____ 5. **REFERRAL AUTHORIZATION** Your insurance carrier may require a referral from your primary care physician for our services. Please be aware that it is your responsibility to obtain all necessary referrals prior to therapy. If your insurance carrier requires and authorization for service, no service will be rendered until the authorization is obtained.

X_____ 6. **MEDICARE** Wells Chiropractic is a participating provider of Medicare; as such we will handle all billing to Medicare and any secondary insurance. Medicare requires you to satisfy a yearly deductible before they will begin paying benefits. Medicare will deduct the deductible amount from the first claim they receive each calendar year. Unless you have satisfied your annual deductible with another Medical provider's office, you are responsible to pay your deductible to Wells Chiropractic. After your deductible is satisfied, Medicare will reimburse us 80% of their standard fee for Chiropractic adjustments ONLY. Therefore your payment responsibility of 20% of the standard Medicare fee for Chiropractic Adjustments, along with any additional products or services you have consented to and received. In the event of a secondary insurance, the 20% will be forwarded to that plan.

I understand that in certain circumstances, Medicare may find that Chiropractic treatments are NOT "reasonable and/or medically necessary" for the illness, injury or condition for which I am seeking treatment. I understand that Medicare bases this ruling on the diagnosis provided by my physician and their standards for that diagnosis. I understand that, in this case, I will be responsible for any and all charges incurred.

X_____ 7. **REVOCATION OF AUTHORIZATIONS** These authorizations may be revoked by me, in writing, at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

X_____ 8. **PATIENT ACKNOWLEDGEMENT** I certify that the information I provided to my doctors, therapists and insurance company is correct. I certify that I am here to receive medical care and for no other

purposes. I do not represent a 3rd party.

X_____ 9. **AUTHORIZATION FOR DISCLOSURE OF INFORMATION**

I, (patient/guardian) _____ authorize, Dr. Wells and her team to disclose all or part of the medical record of (patients name) _____ to any company that may be responsible for payment of all or part of this patient's medical charges. Disclosure of records may be necessary to determine eligibility for liability that may arise from disclosure of these records. I understand that I may revoke this authorization at any time in writing except to the extent that Wells Chiropractic has already taken action on my claim.

Credit Card Payment Authorization **THIS will ONLY be used in the event you exhaust your two grace missed appointments. This will NOT be used for visit transactions, unless requested by you. Please do NOT leave this blank.**
Please complete in its entirety and sign

I (patient/guardian) _____ , hereby authorize Wells Clinic and/or staff to charge my credit card for services rendered, products supplied or NO-SHOW charges for a period of one year from the date below. It is my responsibility to notify Wells Chiropractic of any changes regarding this credit card authorization.

Name on Card	Signature	Date
Credit Card Type ☐ MC ☐ VISA ☐ Am Exp. ☐ Discover	Credit Card Number	
Expiration Date	Security Code	Billing Zip Code