New Patient Intake Form

Arctic Chiropractic Juneau
2243 Jordan Ave. Juneau, AK 99801

Ph: 907-790-3371
Fax: 907-313-6812

Patient Name: _____ **Preferred Name:** _____ **Date:** _____

Date of Birth: _____ Age: _____ Sex: M F Marital Status: M S D W

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security Number: _____ Email: _____

Primary Insurance: _____ Primary Insurance number: _____

Primary Subscriber's Full Name: _____ Primary Subscriber's Date of Birth: _____

Secondary Insurance: _____ Secondary Insurance number: _____

Secondary Subscriber's Full Name: _____ Secondary Subscriber's Date of Birth: _____

Tertiary Insurance: _____ Tertiary Insurance number: _____

Tertiary Subscriber's Full Name: _____ Tertiary Subscriber's Date of Birth: _____

Emergency contact: _____ Emergency contact number: _____

Primary care provider: _____ Primary care contact number: _____

Have you received chiropractic care before? (circle one) YES or NO If yes, when? _____

Have you received physical therapy before? (circle one) YES or NO If yes, when? _____

Have you received massage therapy before? (circle one) YES or NO If yes, when? _____

Surgeries

Date	Type of surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Previous injury or trauma

Date	Type of injury
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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Arctic Chiropractic Juneau Patient Name: _____ Date: _____

Family health history (please circle all that apply)

□ Cancer	□ Strokes/TIAs	□ Autoimmune conditions	□ Neurological disease
□ Diabetes	□ Cardiac disease below age 40	□ Migraines	□ Psychiatric disease
□ Other _____		□ Adopted/Unknown	□ None of the above

Deaths of immediate family members (parents, siblings, grandparents)

Relationship	Cause of death	Age at time of passing

Social and occupational history

Job description: _____

Work schedule: _____

Recreational activities: _____

Exercise habits: _____

Dietary habits: _____

Water intake (per day on average): _____

Alcohol use (per week on average): _____

Tobacco use (per week on average): _____

Drug use (per week on average): _____

Medications

Medication	Reason for taking the medication

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Arctic Chiropractic Juneau Patient Name: _____ Date: _____

Review of Systems (Please circle all that apply)

Have you had any of the following **pulmonary (lung-related)** issues?

□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?

□ Hypertension □ Irregular heartbeat □ Murmurs or valvular disease □ Heart attack/MI
□ Pacemaker □ Angina/chest pain □ Congestive heart failure □ Heart disease
□ Heart surgery □ Other _____ □ None of the above

Have you had any of the following **neurological (nerve-related)** issues?

□ Visual changes/loss of vision □ History of seizures □ Vertigo □ Headaches
□ One-sided decreased feeling of face or body □ Loss of sense of smell □ Memory loss □ Strokes/TIAs
□ One-sided weakness of face or body □ Tremors □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?

□ Diabetes □ Thyroid disease □ Injectable steroid replacements
□ Hormone replacement therapy □ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?

□ Renal calculi/stones □ Bladder Infections □ Dialysis
□ Hematuria (blood in the urine) □ Difficulty urinating □ Kidney disease
□ Incontinence (can't control) □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?

□ Nausea □ Difficulty swallowing □ Bloody or black tarry stools □ Frequent abdominal pain
□ Constipation □ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux (heartburn)
□ Hiatal hernia □ Ulcerative disease □ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?

□ Anemia □ Sickle-cell anemia □ Anticoagulant therapy □ Enlarged lymph nodes
□ HIV positive □ Regular aspirin use □ Hypercoagulation or deep venous thrombosis/history of blood clots
□ Hemophilia □ Anticoagulant therapy □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve)
□ Other _____ □ None of the above

Have you had any of the following **oncological (cancer-related)** issues?

□ Current/past oncology disease (please describe): _____
□ Fevers/chills/sweats/unexplained weight loss □ Abnormal bleeding/bruising
□ Other _____ □ None of the above

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Arctic Chiropractic Juneau Patient Name: _____ Date: _____

Review of Systems (cont.)

Have you had any of the following **dermatological (skin-related)** issues?

□ Significant burns	□ Significant rashes	□ Skin grafts
□ Psoriatic disorders	□ Other _____	□ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?

□ Rheumatoid arthritis	□ Broken bones	□ Spinal fracture	□ Spinal surgery	□ Gout
□ Osteoarthritis	□ Joint surgery	□ Arthritis (unknown type)	□ Scoliosis	□ Metal implants
□ Other (and details of selected)_____				□ None of the above

Have you had any of the following **psychological** issues?

□ Psychiatric diagnosis	□ Psychiatric hospitalizations	□ Schizophrenia	□ Depression	□ Bipolar disorder
□ Homicidal ideations	□ Suicidal ideations	□ Other _____		□ None of the above

Women's health:

Are you pregnant? (circle one): **Yes** or **No**	If yes, what is your due date? _____
Have there been any complications (circle one): **Yes** or **No**	If yes, what complications? _____
Do you have any other children? How many?_____	

Please list anything else in your past medical history that you feel is important to your care here:

_____

_____

_____

_____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic care, physical therapy, and medical massage therapy, in accordance with this state's statutes.

_____ _____

Patient or Guardian Signature Date

Arctic Chiropractic Juneau Patient Name: _____ Date: _____

SYMPTOM HISTORY FORM

Symptom 1 (please describe)**: _____**

- On a scale from 0-10, with 10 as the worst, circle the number that best describes the symptom most of the time:

0	1	2	3	4	5	6	7	8	9	10

- Circle what percentage of the time you are awake do you experience the above symptom at the above intensity:

5	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95	100

- Did the symptom begin **suddenly** or **gradually**? (circle one)
- When did the symptom begin?_____
- How did the symptom begin?_____
- Since the symptom began, has it been **getting better**, **getting worse**, or **staying the same**? (circle one)
- What makes the symptom worse? (circle all that apply):

Nothing	All movement	Looking downward	Looking upward
Turning head	Bending forward at waist	Bending backward at waist	Turning at the waist
Jumping/impact	Taking the stairs	Reaching overhead	Reaching behind the back
Chewing	Prolonged positions	Lifting	Driving
Standing	Walking	Running	Exercising
Working	Sitting	Getting up from seated position	Lying on side in bed
Gripping	Squatting	Other (please specify)_____	

- What makes the symptom better? (circle all that apply):

Nothing	Resting	Ice	Heat	Stretching	Exercise
Walking	NSAIDs	Muscle relaxers	Massage	Chiropractic adjustments	
Other (please describe): _____					

- Describe the quality of the symptom (circle all that apply):

Sharp	Dull	Achy	Burning	Stiff	Stinging	Nagging	Deep	Stabbing	Throbbing	Piercing
Other (please describe)_____										

- Does the symptom radiate to another part of your body (circle one): YES or NO
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle all that apply)

Morning	Midday	Afternoon	Evening	Night	No specific time is worse than others

- What providers have you seen for this condition and episode prior to today's visit? (circle all that apply)

MD/DO	Chiropractor	Physical Therapist
Orthopedist	Neurologist	Massage Therapist
ER/Urgent Care	Acupuncturist	Naturopath
Other (specify)_____		None

- What treatments for this condition and episode have you had prior to today's visit? (circle all that apply)

Cortisone injections	Surgery	Massage therapy
Trigger point injections	Acupuncture	Physical Therapy
Chiropractic X-Ray	MRI	CT scan
Medication (specify)_____		
Other (specify)_____		None

Reviewed by doctor: _____

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SYMPTOM HISTORY FORM

Symptom 2 (please describe)**:** _____

- On a scale from 0-10, with 10 as the worst, circle the number that best describes the symptom most of the time:

0	1	2	3	4	5	6	7	8	9	10

- Circle what percentage of the time you are awake do you experience the above symptom at the above intensity:

5	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95	100

- Did the symptom begin **suddenly** or **gradually**? (circle one)
- When did the symptom begin?_____
- How did the symptom begin?_____
- Since the symptom began, has it been **getting better**, **getting worse**, or **staying the same**? (circle one)
- What makes the symptom worse? (circle all that apply):

Nothing	All movement	Looking downward	Looking upward
Turning head	Bending forward at waist	Bending backward at waist	Turning at the waist
Jumping/impact	Taking the stairs	Reaching overhead	Reaching behind the back
Chewing	Prolonged positions	Lifting	Driving
Standing	Walking	Running	Exercising
Working	Sitting	Getting up from seated position	Lying on side in bed
Gripping	Squatting	Other (please specify)_____	

- What makes the symptom better? (circle all that apply):

Nothing	Resting	Ice	Heat	Stretching	Exercise
Walking	NSAIDs	Muscle relaxers	Massage	Chiropractic adjustments	
Other (please describe): _____					

- Describe the quality of the symptom (circle all that apply):

Sharp	Dull	Achy	Burning	Stiff	Stinging	Nagging	Deep	Stabbing	Throbbing	Piercing
Other (please describe)_____										

- Does the symptom radiate to another part of your body (circle one): YES or NO
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle all that apply)

Morning	Midday	Afternoon	Evening	Night	No specific time is worse than others

- What providers have you seen for this condition and episode prior to today's visit? (circle all that apply)

MD/DO	Chiropractor	Physical Therapist
Orthopedist	Neurologist	Massage Therapist
ER/Urgent Care	Acupuncturist	Naturopath
Other (specify)_____		None

- What treatments for this condition and episode have you had prior to today's visit? (circle all that apply)

Cortisone injections	Surgery	Massage therapy
Trigger point injections	Acupuncture	Physical Therapy
Chiropractic X-Ray	MRI	CT scan
Medication (specify)_____		
Other (specify)_____		None

Reviewed by doctor: _____

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Patient-Specific Functional Scale

Please identify up to five important activities that you **are unable to do or have difficulty doing** as a result of your current symptoms. Write these down in the spaces provided below, then rate your ability to perform the activity in the last week by circling the appropriate number.

Activity 1:_____

Unable to perform	0	1	2	3	4	5	6	7	8	9	10	Able to perform without issue

Activity 2:_____

Unable to perform	0	1	2	3	4	5	6	7	8	9	10	Able to perform without issue

Activity 3:_____

Unable to perform	0	1	2	3	4	5	6	7	8	9	10	Able to perform without issue

Activity 4:_____

Unable to perform	0	1	2	3	4	5	6	7	8	9	10	Able to perform without issue

Activity 5_____

Unable to perform	0	1	2	3	4	5	6	7	8	9	10	Able to perform without issue

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Arctic Chiropractic Juneau LLC

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSERS OF PROTECTED HEALTH INFORMATION THAT WE MAY MAKE WITHOUT YOUR AUTHORIZATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, support the operation of the physician's practice and any other use required by law.

- **To contact you** - Your information may be used to contact you to remind you about appointments, inform you about treatment options or advise you about other health-related benefits and services.
- **Treatment** – Your information may be shared with any healthcare provider who is providing you with health care services. This includes coordinating your care with other health care providers and providing referrals to other health care providers. Examples of healthcare providers who may need your information to treat you include your doctor, pharmacist, nurse and other providers such as physical therapists, massage therapists, home healthcare providers and X-ray technicians. We may share your PHI electronically with your healthcare providers to make sure they have your information as quickly as possible to treat you.
- **Payment** – In order to obtain payment for your health care services, we may have to provide your PHI to the party responsible for paying. This may include Medicare, Medicaid or your insurance company. Your insurance company may need information about activities such as your eligibility of coverage, reviewing the medical necessity of the health care services provided to you or providing approval for specific services.
- **Healthcare Operations** - We may use or disclose, as needed, your PHI in order to support the business activities of our physician's practice. These activities include, but are not limited to quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign in sheet at the front desk where you will be asked to sign your name and/or indicate your physician, as well as the time you arrived and left our office. We may also call you by name in the waiting room, when your physician is ready to see you. We may share your PHI with third parties who perform services such as transcription or billing. In those cases, we have written agreements with the third parties that they will not use or disclose your PHI except if permitted by law. We may also use your information (name, address, date of birth, department of service, treating physician, dates of treatment, outcome) for our fundraising activities.

OTHER USES AND DISCLOSURES THAT WE MAY MAKE WITHOUT YOUR AUTHORIZATION

There's a number of ways that your PHI may be used or disclosed without your authorization. Generally, these uses and disclosures are either required by law or for public health and safety purposes.

- When required by law;
- Public Health issues;
- Health oversight;
- Legal proceedings;
- Abuse & Neglect;
- Law Enforcement;
- Preventing a serious threat to the health and safety of a person or of the public;
- Coroners, Funeral Directors and Organ Donation;
- Research;
- Military Activity and National Security;
- Worker's Compensation

- Inmates/arrestees;
- Disaster relief;

Other permitted and required uses and disclosures will be made only with your written authorization. You may revoke an authorization in writing at any time except to extent that your physician or the physician's practice has taken an action in reliance on the authorization.

YOUR RIGHTS

- **Access to your PHI** – You have the right to receive a copy of your health information that we maintain, with some limited exceptions. You may request access to your information in writing, and you may request a copy of your information in electronic format. We reserve the right to charge a reasonable fee for the cost of producing and providing your health information. You have the right to request that your health information be sent to any person or entity, such as another doctor, caregiver or online personal health record.

- **You have the right to request a restriction of your PHI** - This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If a physician believes that it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have to use another healthcare professional.

- **Confidential communications** – We will accommodate reasonable requests to communicate with you about your health information by different methods or alternative locations. For example, if you are covered on a health plan but are not the subscriber, and would like your health information sent to a different address than the one of the subscriber, we can usually do that for you.

- **Breach Notification** – You have the right to receive notification of breaches of your health information as required by law.

- **You may have the right to have your physician amend your PHI** - If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

- **You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI** - We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

QUESTIONS AND COMPLAINTS

If you have any questions or are concerned that any of your privacy rights have been violated, please contact the Secretary of Health and Human Services at:

Office of Civil Rights – AK, WA, OR, MT
U.S.Department of Health and Human Services
2201 Sixth Avenue – M/S: RX-11
Seattle, WA 98121-1831

CHANGES TO OUR PRIVACY POLICY

We reserve the right to change the terms of our Notice at any time. New Notice provisions will be effective for all PHI that we maintain. You may view a copy of our most current Notice on our website at www.arcticchiropracticjuneau.com, in the lobby at our office, or request a current copy from the medical records department or privacy officer at any time.

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main office number.

Revised July 14, 2014

HIPAA Consent Form

HIPAA – NOTICE OF PRIVACY PRACTICES

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practice is to explain how Arctic Chiropractic Juneau LLC may use or disclose your health information. The Notice also explains the rights that you are guaranteed under HIPAA regulations. Though Arctic Chiropractic Juneau LLC has always taken great care to protect the integrity and confidentiality of your health information, we are now required by the HIPAA Privacy Rule to distribute the notice to you and obtain acknowledgement that you have received the notice. Signing below indicates that you have received the Notice of Privacy Practice. If you have any questions, please contact our HIPAA Compliance Officer below:

Temenuga Chavis
2243 Jordan Ave
Juneau, AK 99801

I hereby acknowledge that I have received a copy of Arctic Chiropractic Juneau's Notice of Privacy Practices.

_____ _____

Signature of Patient/ Guardian (if Guardian, please provide relationship to patient) *Date*

I, _____ give permission to Arctic Chiropractic Juneau LLC to discuss the following medical information about me (check all boxes that apply):

□ Scheduling/Appointment information

□ Medical information, including my symptoms, diagnosis, medications and treatment plan

□ Billing and Payment information

Arctic Chiropractic Juneau has my permission to discuss this information with:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

CONSENT TO BILL INSURANCE PLAN(S)

By my signature below, I authorize Arctic Chiropractic Juneau LLC to bill my insurance company for the medical services provided to me. I authorize payment directly to my doctor and I permit this form to be used as "Signature On File" for all my insurance submissions. I understand that in order to obtain payment, my doctor may share exchange health information which may include diagnosis, service dates, types of services and other information that is necessary to process my claims. I understand that if payment is made directly to me for services provided by Arctic Chiropractic Juneau LLC, I am responsible for immediately sending such payments to the clinic. I am responsible to notify Arctic Chiropractic Juneau LLC of any changes in my health insurance coverage, as well as any denial information. I understand that I AM RESPONSIBLE for payments to Arctic Chiropractic Juneau LLC for charges regardless of my insurance coverage. I also understand that in the event my insurance company denies payment, I am responsible for the balance in full. I am aware that I am responsible for any co-payments and/or yearly deductible as specified under my insurance contract.

_____ _____

Signature of Patient/ Guardian (if Guardian, please provide relationship to patient) *Date*

Arctic Chiropractic Juneau

Financial Agreement Policy

We want to thank you for choosing Arctic Chiropractic Juneau as your health care provider. Our staff is dedicated to providing outstanding medical care to our patients. We do our best to be helpful and informative in the area of financial obligation. Feel free to let us know if you ever have any questions or concerns about this policy, we'd be glad to answer any questions. Please, read our financial agreement policy and let us know which option would be best for you.

Patients Without Insurance

If you do not have insurance, we expect payment in full at the time of service. For your convenience we accept cash, check, Visa, MasterCard, Discover, American Express and CareCredit. You may also choose to leave your signature and credit card on file; with your authorization, we will charge your card monthly for the balance on your account.

Patients With Insurance

Due to the fact that insurance plans differ and can be sometimes confusing, we will do our best to assist you. We will prepare your insurance claims for you and send them to your insurance. We will also bill your secondary insurance if you have one. We always make sure we re-submit any claims that haven't been processed and do our best to figure out why a claim or a service was denied/unpaid. Our goal is to make sure your claims are processed and paid without any hassle or problems. In order for us to do so, please inform us of any changes in your name, address, insurance. We will let you know if you need to contact your insurance company in order for claims to be processed, sometimes this is needed as they periodically they need to update information about subscribers or simply have some questions before they can process your claim. Under this agreement, you are responsible for paying your co-pays, non-covered portions, or any annual deductible that has not been satisfied yet. For your convenience we accept cash, check, Visa, MasterCard, Discover, American Express and CareCredit. You may also choose to leave your signature and credit card on file; with your authorization, we will charge your card monthly for the balance on your account. ***Please, note that you are responsible to know and understand your insurance policy and you are responsible to pay Arctic Chiropractic Juneau LLC your account balance if your insurance doesn't pay.***

A word about our Fees

Our charges are based on Alaska Workers' Compensation Fee Schedule (for more information go to *http://labor.state.ak.us/wc*) and are within the "reasonable and customary" range by most insurance plans; however, some insurance companies have determined their own "payment schedule", which sometimes could be more or less than our fees. Please, note that some services may be considered as non-covered under the policy limitations.

PLEASE, CHECK ONE OF THE FOLLOWING:

WITH INSURANCE:

□ I prefer that you bill my insurance company, I will pay my co-pay and/or my office visit charge on ***each visit***.

□ I prefer that you bill my insurance and charge my credit card monthly for the balance on my account.

WITHOUT INSURANCE:

□ I prefer to pay if full on each visit.

□ I prefer you to charge my credit card monthly for the balance on my account.

_____

Patient Name Signature Date

Print Name if not signed by patient: _____