Patient Intake Form

Name: _____ **Date:** _____

Date of Birth: _____ ☐ Male ☐ Female ☐ Other

Address: _____

_____

Marital Status:

S M W D SEP

SSN#: _____

Insurance: _____

Phone #: Cell: _____ Other: _____

E-Mail: _____

Occupation/Employer: _____

Note: Patient information contained within this form is considered strictly confidential. Your responses are important to help us better understand your health issues you face and ensure the delivery of the best possible treatment.

Emergency Contact: _____

Phone number: _____

Check boxes and indicated the age when you had any of the following:

General:

- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of Sleep
- ☐ Mental Illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss/gain

Muscle / Joint:

- ☐ Arthritis/Rheumatism
- ☐ Bursitis
- ☐ Foot Trouble
- ☐ Muscle Weakness
- ☐ Low back Pain
- ☐ Neck Pain
- ☐ Mid Back Pain
- ☐ Joint pain

Skin:

- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or Allergies
- ☐ Itching
- ☐ Rash

Eye, Ear, Nose, & Throat:

- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum Trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sore throat
- ☐ Tonsillitis
- ☐ Vision problems
- ☐ Sinus infection

Gastrointestinal:

- ☐ Abdominal Pain
- ☐ Bloody or Tarry Stool
- ☐ Colitis/Crohn's
- ☐ Colon Trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult Digestion
- ☐ Diverticulosis
- ☐ Bloated Abdomen
- ☐ Excessive Hunger
- ☐ Gallbladder Trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal Worms
- ☐ Jaundice
- ☐ Liver Trouble
- ☐ Nausea
- ☐ Vomiting Blood
- ☐ Pain over stomach
- ☐ Poor Appetite
- ☐ Vomiting

Women Only:

- ☐ Congested breast
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual Flow:

Days of flow: _____

Length of cycle: _____

Date: 1st day of last period: _____

would you say flow is:

☐ Reg. ☐ Irreg.

Are you pregnant? _____

If yes, how many months? _____

How many children do you have? _____

Birth control method: _____

Date of last PAP test: _____ ☐ Normal ☐ Abnormal

Date of last mammogram: _____ ☐ Normal ☐ Abnormal

Cardiovascular:

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pules
- ☐ Pain over heat
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heartbeat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory:

- ☐ Chest Pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay Fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Genitourinary:

- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate troubles
- ☐ Pus in urine
- ☐ Stress incontinence
- ☐ Painful urination

Check any of the conditions you have or have had:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart Burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Patient Intake Form

Please list any medications/supplements you are currently taking and why: _____

_____

_____

What is the purpose of your visit today? _____

What is your primary complaint? _____

Any other complaints? _____

What caused the current condition? _____ **When did it start?** _____

Does the pain radiate? If so, where?

_____

(Please circle your answers below)

Since your condition started, how has it changed? Getting Better Not Changing Getting Worse

How often do you experience this complaint? Constantly (100%) Frequently (75%) Occasionally (50%) Intermittently (<50%)

Does your complaint worsen? If so, when: Morning Midday Night Work Sleep Other _____

How much has the complaint interfered with your normal day to day life? (Work, outside the home, and housework)

Not at all A little bit Moderately Quite a bit Extremely

How much would you say this complaint has affected your social activities?

All the time Most of the time Half of the time Some of the time Not at all

Severity:

Use this key below to rate the severity of your pain. Please write in your number: _____

0 = No Pain 1 = Minimal 2 = Very Mild 3 = Mild 4 = Mild to Moderate 5 = Moderate 6 = Moderate to Severe 7 = Mildly Severe 8 = Severe 9 = Very Severe 10 = Excruciating

Quality: How would you describe the current sensation of your complaint?

☐ Sharp pain ☐ Shooting pain ☐ Numbness ☐ Tingling ☐ Dull Ache ☐ Burning ☐ Throbbing

☐ Other_____

Previous Treatment:

Who have you seen for this condition?

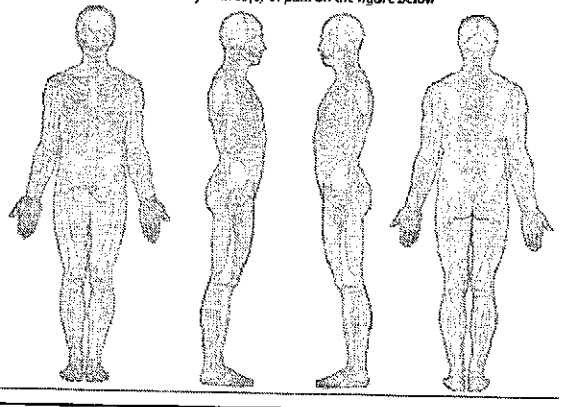
☐ Medical Doctor ☐ Physical Therapist

☐ Chiropractor ☐ Other _____

Have you had Chiropractic/Physical Therapy care in the past?

☐ Yes ☐ No If so, When? _____

Please mark you area(s) of pain on the figure below



Family History:

If any blood relatives has had any of the following conditions,
Please check and indicate which relative(s)

☐ Alcoholism	☐ Cancer	☐ High Blood Pressure
☐ Anemia	☐ Diabetes	☐ High Cholesterol
☐ Arteriosclerosis	☐ Emphysema	☐ Multiple Sclerosis
☐ Arthritis	☐ Epilepsy	☐ Osteoporosis
☐ Asthma	☐ Glaucoma	☐ Stroke
☐ Bleed easily	☐ Heart Disease	☐ Thyroid disease

Please note any additional information we may need to know in regards to your family history:

_____

_____

Habits:	None	Light	Mod.	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Water	☐	☐	☐	☐
Sugars	☐	☐	☐	☐

Any additional habits that are not listed above:

Patient Signature: _____ Date: _____ Reviewed by Doctor: _____

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 pf 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 nay 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

Please, retain for your records

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*

INFORMED CONSENT FOR PHYSICAL THERAPY SERVICES

Arctic Chiropractic Juneau LLC

Physical Therapy: The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation and intervention by use of rehabilitative procedures, mobilization, manual techniques, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to me before they are performed.

Informed Consent for Treatment: The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. I understand that the physical therapist provides a wide range of services and I will receive information at the initial visit concerning the treatment and options available for my condition. I will notify my practitioner if I am pregnant, become pregnant, or am trying to get pregnant. I understand I am encouraged to communicate with a physician the potential benefits and risks of treatment relevant to my pregnancy.

Potential Benefits: Benefits may include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the recourses available to me.

Potential Risks: I may experience an increase in my current level of pain or discomfort, or aggravation of my existing injury during physical therapy. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

No Warranty: I understand that my physical therapist cannot make any promises or guarantees regarding a cure for or improvements in my condition. I understand that my physical therapist will share with me her/his opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Insurance: I, the patient, am ultimately responsible for payment of my account. As a courtesy, Arctic Chiropractic Juneau LLC will bill my insurance company on my behalf. I am responsible for paying any deductible and/or co-payment due at time of service. After 60 days any balance not paid by insurance will become my responsibility.

Cancellation Policy: In the event that I need to cancel a scheduled appointment, I agree to provide the courtesy of 24- hours notice, so that Arctic Chiropractic Juneau LLC can offer my appointment to patients, waiting on the standby list. If I miss 3 scheduled appointments, without giving Arctic Chiropractic Juneau any notice, I will not be able to schedule any physical therapy appointments in the future.

I have read the above information and I consent to physical therapy evaluation and treatment. My signature below acknowledges that I have read, understood and will abide by the conditions and policies noted on this consent form.

Name of patient / Guardian of patient Signature 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: _____

Revised 9/2014