My Chiropractic Doctor

Patient Intake Form

Patient Information

Full Name _____ **Date:** _____
First MI Last

Address _____ **City** _____ **State** _____ **Zip** _____

Age _____ **Birthdate:** _____ Male: ____ Female: _____ **Marital Status:** _____

Social Security Number: _____ **Email** _____

Home Phone: _____ **Work Phone:** _____ **Cell/Other:** _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA **Text Message** to my cell phone: **Y / N** **Please list your cell phone carrier:** _____

Employer: _____ **Occupation:** _____

How did you hear about our office? _____

Primary Language Spoken_____ Race_____ Ethnicity_____

Emergency Contact Information

Spouse's Name: _____ **Spouse's Date of Birth:** _____

Emergency Contact: _____ **Emergency Contact Phone Number:** _____

Payment Information

Please have your insurance card and photo ID ready so they can be copied for the clinic's records.

Person Responsible for Payment: _____ Phone**:** _____

Do you have health insurance**?** Yes No Who is the policy holder? _____

Policy Holder's date of birth: _____

Financial Responsibility: I understand that insurance billing is a courtesy provided to me by My Chiropractic Doctor and I am at all times financially responsible for any charges no covered by health care benefits. I understand copays, co-insurance, and deductibles are due at the time of my visits as well as any prior balance I may owe. I understand that I assign benefit to be paid by my insurance company directly to the provider of services rendered to me. I understand my balance will automatically be referred to an outside collection agency should my account surpass 90 days without payment activity. I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for medical services and / or supplies received.

Authorization for Release of Information

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members, you must sign this form. Signing this form will only allow us to give information to family members indicated below.

I authorize My Chiropractic Doctor to release my medical and / or billing information to the following individual (s):

1. _____ **Relation to Patient:** _____
2. _____ **Relation to Patient:** _____

Consent for Treatment

Assignment & Release- By signing below, I authorize My Chiropractic Doctor to release medical records required by my insurance company(s).
I authorize my insurance company(s) to pay benefits directly to My Chiropractic Doctor and I agree that a reproduced copy of this authorization will be
as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment and health care operations**.**

By signing below, I give my consent for examination and the performances of any tests or procedures needed. I, the undersigned, understand and agree to the above terms.

Patient/Guardian Signature _____ **Date** _____

If patient is a minor, by signing below I give consent for examination, tests and procedures for the minor patient.

Parent/Guardian Signature _____ **Date** _____

Office Policies

Thank you for selecting our office to provide chiropractic care to you and your family members. Please note the following office policies:

Payment Policy: Payment is required at the time of service or at the time of purchase of any supports or supplies. Payments can be made by cash, Visa, MasterCard, Amex, and Discover.

Re-exam Policy: If a patient has not been seen in our office for 90 days, they present with a new injury or area of complaint, or if insurance has changed they will be subject to a re-examination and a subsequent re-exam charge.

Cell Phone Policy: In an effort to keep a relaxing environment, please silence your cell phones and all electronic devices while in the office and please step outside to make or receive phone calls.

Treatment Plan: After your initial visit you will be given a treatment plan. We request that you follow that plan to get the results we both desire. If you need to change an appointment, please keep as close to the original plan as possible so the continuity of your treatment will not be interrupted

I, the undersigned, understand and agree to the above and, in order to be accepted as a new patient in this office, agree to abide by these policies.

Signature _____ **Date** _____

Health Questionnaire

Patient Information

Patient Name _____ **Date of Birth** _____

Medical History

Describe your reason for today's visit: **Date of Onset:** _____

Describe onset: Acute Chronic Gradual **Cause:** Unknown Accident

Prior pain to this area: None On and off for years Years ago **Side**: Left Right Bilateral

Describe your pain: (Circle one or more) Achy Burning Dull Sharp Stiff Throbbing

Description of Pain: Mild Moderate Severe **Pain level (1-10):** _____

Does the pain radiate to other areas? _____

When is your pain the worst? Morning As day progresses Afternoon Evening During the night No change

What exacerbates this condition? _____**What alleviates symptoms?** _____

Do you have numbness? Y / N If so, where? _____

Do you have spasms? Y / N If so, where? _____

Do you have weakness? Y / N If so, where? _____

Do you have limited range of motion? Y / N If so, where? _____

Pain with movement? Y / N If so, where? _____

History of Treatment

Primary Care Physician _____**Phone** _____

Have you seen another doctor for these symptoms? If yes, who? _____

List all prescription, nonprescription medications and other supplements you take as well as the associated condition

_____

List any surgeries or hospitalizations you have had complete with the month and year for each _____

_____

List any allergies _____

Family History (list all major diseases such as cancer, diabetes, heart problems, etc. and the relation to you and the individual)

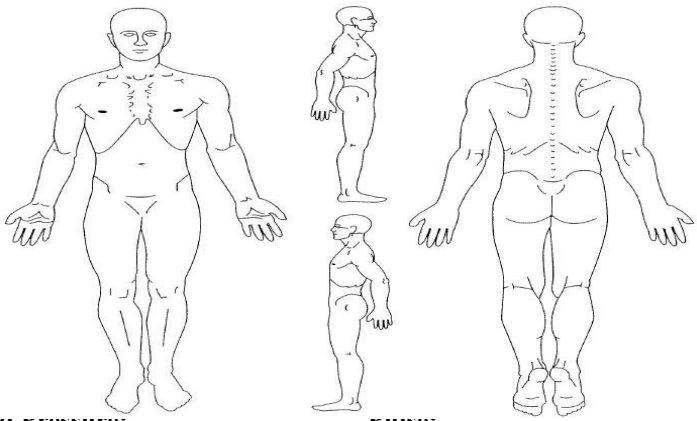
_____

_____

Do you smoke? Yes No **If yes, how many packs per day?** _____ **Are you pregnant?** Yes No

Description of Condition

Please circle the area (s) of discomfort:



Height: _____ **Weight:** _____ **Blood Pressure:** _____ **Pulse:** _____

Review of Systems

(Indicate if you have had conditions in the past or presently have the conditions)

Cardiovascular	Past	Present		**Respiratory**	Past	Present		**Allergic/Immunologic**	Past	Present
Poor Circulation				Asthma				Hives		
Hypertension				Tuberculosis				Immune Disorder		
Aortic Aneurism				Short Breath				HIV/AIDS		
Heart Disease				Emphysema				Allergy Shots		
Heart Attack				Cold/Flu				Cortisone Use		
Chest Pain				Cough						
High Cholesterol				Wheezing						
Pace Maker								**Ear, Nose and Throat**	Past	Present
Jaw Pain /TMJ				**Eyes**	Past	Present		Difficulty Swallowing		
Irregular Heartbeat				Glaucoma				Dizziness		
Swelling of legs				Double Vision				Hearing Loss		
				Blurred Vision				Sore Throat		
Genitourinary	Past	Present						Nosebleeds		
Kidney Disease				**Psychiatric**	Past	Present		Bleeding Gums		
Burning Urination				Depression				Sinus Infections		
Frequent Urination				Anxiety						
Blood in Urine				Stress				**Gastrointestinal**	Past	Present
Kidney Stones								Gall Bladder Problems		
Lower Side Pain				**Endocrine**	Past	Present		Bowel Problems		
				Thyroid				Constipation		
Neurologic	Past	Present		Diabetes				Liver Problems		
Stroke				Hair Loss				Ulcers		
Seizures				Menopausal				Diarrhea		

Head Injury				Menstrual				Nausea/Vomiting		
Brain Aneurysm								Bloody Stools		
Numbness				**Hematologic**	Past	Present		Poor Appetite		
Severe Headaches				Hepatitis						
Pinched Nerves				Blood Clots				**Musculoskeletal**	Past	Present
Parkinson's				Cancer				Gout		
Carpal Tunnel				Bruising				Arthritis		
Vertigo				Bleeding				Joint Stiffness		
				Fever, Chills				Muscle Weakness		
Constitutional	Past	Present		Sweating				Osteoporosis		
Difficulty Sleeping								Broken Bones		
Weight Loss/Gain								Joints Replaced		

Patients Signature: _____ Date: _____

My Chiropractic Doctor

Late and Missed Appointment Policy

At My Chiropractic Doctor Clinic, we trust you to keep your appointment. When we schedule an appointment, a specific amount of time is reserved especially for you. If, for any reason, you are unable to attend your appointment, it is important that you notify our office at least **24 hours in advance** to offer it to someone else. That said, we require a credit card be stored on file to be used in the event an appointment is missed.

- First Missed Appointment - If an appointment is missed or canceled within the 24 hour period, we *may* waive the missed queue appointment fee.

- Second Missed Appointment: After your second missed appointment, we reserve the right to charge up to $50 for each scheduled half-hour appointment.

We understand that true emergencies happen. If this is the case, please send us a doctor's note, or another form of appropriate proof, and the missed appointment will be removed from your account record.

Late arrival
When we set aside time for you, we need every second of that time to provide you with the best quality work possible. When you are late, it diminishes our ability to achieve this. If you are more than 15 minutes late, your appointment may be rescheduled to accommodate the needs of those arriving on time for their pre-booked visit. If this happens, it will be considered a missed appointment and you may be charged a fee at the time of the visit.

I, the undersigned, understand and agree to the above and, in order to be accepted as a new patient in this office, agree to abide by these policies.

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other

Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy):_____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize My Chiropractic Doctor to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Signature: _____ Date: _____

My Chiropractic Doctor

HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights are given to me under the Health Information Portability and Accountability Act of 1996 (HIPAA). Signing this consent allows My Chiropractic Doctor to use and disclose my protected health information for:

- Treatment
- Consulting with other health care providers about my case
- The day-to-day healthcare operations of your practice

I have also received a copy of your *Notice of Privacy Practices*, which more fully explains how my PHI may be used and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice and that I may contact you at any time to get the most current copy.

I understand that I have the right to request restrictions on how my PHI is used and disclosed but that you are not required to agree to these requests. However, if you do agree you must abide by these restrictions.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to that date is not affected.

I HAVE READ THIS CONSENT FORM AND UNDERSTAND WHAT I HAVE READ. I CONFIRM THAT ALL MY QUESTIONS HAVE BEEN ANSWERED AND I AGREE TO THE ABOVE STATEMENTS.

Printed Name: _____ Date: _____
Signature: _____

My Chiropractic Doctor

OUT OF POCKET SERVICES:

CUPPING ……. $55.00

- 1ST VISIT: 10 - 15 MINUTES
- 2ND VISIT: 20 - 30 MINUTES

NOTE: 1-2 AREAS AT ONLY 2X PER MONTH

SPINAL DECOMPRESSION ……..…… $98.00 / SESSION

NOTE: ***NOT*** COVERED BY INSURANCE ***NOR*** OFFERED AT DISCOUNTED RATES

NUTRITION WEIGHT LOSS …… $250.00

INCLUDES:

- DIET PROGRAM, MEASURMENTS, AND AN INDIVIDUALIZED WEIGHT LOSS PLAN

NOTE: PRICE REFLECTS 2 WEEK PLAN WITH SERVICES 2X PER WEEK

LIPO-LIGHT ……..……. $75.00 / SESSION

LASER ……... $75.00 / SESSION

In the instance it is recommended by my physician that I incorporate any of the above services alongside chiropractic treatment:

I,_____, hereby acknowledge the above information and understand that all services listed are not covered by my health insurance provider *nor* are they included in any HMP plans. I understand that the cost of service is due in full at the time of scheduling.

Signature: _____ Date: _____

IRREVOCABLE ASSIGNMENT OF BENEFITS, AUTHORIZATION AND LIEN

To Whom It May Concern:

This Irrevocable Assignment of Benefits, Authorization and Lien (this "Assignment") is made by and between _____ ("Patient") and ✓ Dr. Faranak Taheri, DC. My Chiropractic Doctor ("Health Care Provider"). With this Assignment, and in consideration of treatment without having to render concurrent payment, Patient, hereby irrevocably transfers sets over and assigns to Health Care Provider all insurance and/or litigation proceeds to which Patient is now or may hereafter become entitled, including those listed below, up to the total amount due and owing the Health Care Provider for services rendered to the Patient by reason of accident or illness, including interest thereon, as well as any other charges that are due or may become due the Health Care Provider, including, without limitation, requested reports, collection costs and expenses and attorney's fees, and Patient further hereby irrevocably authorizes and directs any insurance company and/or attorney to whom an original or copy of this Assignment is provided to withhold from Patient and pay directly to such Health Care Provider such amount(s) from (1) any insurance benefits payable to Patient or on Patients behalf, including, but not limited to, medical payments benefits, No Fault benefits, health and accident benefits, personal injury protection benefits, third-party liability coverage, foundation grants, governmental or agency benefits, worker's compensation benefits or any other insurance proceeds or benefits of any kind which are payable to or on behalf of the Patient, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgment or verdict in Patients favor as may be necessary to fully pay any and all financial obligations owed to the Health Care Provider by the Patient. This Assignment is to be a complete and current transfer of Patients right, title, and interest, separate from any statutory or contractual lien or claim to which the Health care Provider may also be entitled. Patient acknowledges that Health Care Provider has a substantial pecuniary interest in the enforcement of this Assignment.

The Patient further agrees that, in the event the insurance company and/or attorney obligated hereunder to make payments to the Health Care Provider fails or refuses to make payment for the full amount due as set forth above, this Assignment is a full, immediate and complete assignment of all the Patient's rights, title, interest, remedies and benefits in and to the assigned property to the extent of the Health Care Providers total claim amount; therefore, Patient hereby irrevocably and fully assigns and transfers to the Health Care Provider any and all causes of action that Patient might have or that might exist in Patients favor against such insurance company and/or attorney with respect to the assigned property. In addition to the foregoing assignment, Patient hereby authorizes, nominates and appoints as Patients attorney-in-fact any officer of Health Care Provider, to prosecute said causes(s) of action either in Patients name or in the Health Care Providers name and Patient further authorizes the Health Care Provider to compromise, settle or otherwise resolve said claim(s) or cause(s) of action as it sees fit.

In further consideration of the services provided by the Health Care Provider, Dr. Faranak Taheri,DC, Patient hereby grants a lien to said Health Care Provider against any and all insurance benefits and litigation proceeds outlined in the first paragraph above which may be payable to or on behalf of the Patient as a result of the injuries or illness for which Patient has been treated by said Health Care Provider. The Patient further agrees that the statute of limitations applicable to Health care Providers right to demand payment from the patient shall be tolled for all reasonable times that negotiations or litigation between third parties and the Patient are ongoing.

Patient hereby acknowledges that Virginia law imposes a lien in the amount of $750.00 upon Patients claim against the individual or entity whose negligence is alleged to have caused Patients injuries.

Notwithstanding the foregoing, the Patient agrees that until the Health Care Provider is paid in full, the Patient shall remain personally and fully responsible for and promises to pay the total amount due the Health Care Provider (including principal, interest, collection costs and attorney's fees of 35%) until fully paid. The Patient further understands and agrees that this Assignment does not constitute any agreement of or consideration for the Health Care Provider to await payments from any source, and in the event the Health Care Provider deems itself in its sole discretion insecure as to the prospect payment, it may demand payments from Patient immediately upon rendering services at its option and proceed to collect same through legal means if necessary.

Patient authorizes the Health Care Provider to release this Assignment and any information pertinent to Patients case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. Patient hereby nominates and appoints any officer of the Health Care Provider as Patient's attorney-in-fact to endorse/sign Patient's name on any and all checks for payment of the services provided to Patient by said Health Care Provider.

In the event that any part or provision of this Assignment shall be determined to be invalid or unenforceable, the remaining parts and provisions of this Assignment which can be separated from the invalid, unenforceable provision shall continue in full force and effect.

Notice regarding the assignment of medical expense benefits is provided in a separate document. I have been presented with and had an opportunity to read the notice.

Acknowledged:_____(patient initials)

Witness the following signatures and seal as of the indicated date:

Patient _____

Patients Signature _____

Health Care Provider

Printed Name **My Chiropractic Doctor** (e.g.-Thesier Chiropractic Clinic, P.C).

Date_____ SS#_____ By:_____ It's _____

Witness_____

Date_____

NOTE:

Regarding the Signature section at the bottom of the form - If you are a corporation, put your clinic name under "Health Care Provider." "By" will be your signature and "Its" is your position in the corporation (Owner, President, etc.).

If you are not a corporation, "Its" can be eliminated. For non-corporations, the doctor's name and signature are all that are needed.