New Patient Checklist

For office use only

- ❑ Intake paperwork & review
- ❑ Scan ID & patient insurance
- ❑ Get PCP information
- ❑ Input intake into CT
- ❑ Select primary provider
- ❑ Prepare PCP letter & send
- ❑ Send new patient text on the same day after the appointment
- ❑ Input insurance
- ❑ Scan & shred

Spinal Care Associates

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we can begin any health care treatment we need you to read and sign this consent stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this Chiropractic office to use their Patient Health Information (PHI) for the purposes of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this Chiropractic office to submit requested PHI of the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the Chiropractic Physician has the right to refuse given care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Signature of Patient/Parent or Guardian Date

Office Policy

We invite you to discuss frankly with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Our office policy requires payment in full for all services rendered at the time of your visit, unless other arrangements have been made. If your account is not paid within 90 days from the date of service, and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting on your account.

Authorization and Assignment of Benefits

I hereby authorize payment of benefits directly to provider of benefit due for services rendered. I further authorize the physician and/or supplier to release any information required to process insurance claims.

I also understand it is my responsibility to inform this office of any changes in my medical status or insurance. The information that this office has is correct to the best of my knowledge.

Signature of Responsible Person: _____

Print Name: _____

Date: _____

Confidential Patient Data

Today's Date:

Patient Information

Patient's Last Name: First: MI:	Nickname:	Date of Birth:	Sex: ☐ M ☐ F

Social Security Number:	Marital Status: Single Married Divorced Widowed Other

Address:	City:	State:	Zip Code:

Home Phone:	Work Phone:	Cell Phone:	Preferred Phone: ☐Home ☐Work ☐Cell

E-Mail Address:	Employer:

Emergency Contact Name & Phone Number:

Emergency Contact Address:

Primary Care Physician

Primary Care Physician's Name:	Phone & Location:

Other Patient Information

Referred By:

Current Medications:

1. Drug Name: _____ 2. Drug Name: _____
Frequency (e.g. once daily):_____ Frequency (e.g. once daily):_____

3. Drug Name:_____ 4. Drug Name:_____
Frequency (e.g. once daily):_____ Frequency (e.g. once daily):_____

Smoking Status: ☐Current Every Day ☐ Current Some Days ☐ Former ☐Never Start Year: _____ Quit Date:_____

Alcohol Use: ☐ None ☐ Light ☐ Moderate ☐ Heavy	Recreational Drug Use: ☐ None ☐ Light ☐ Moderate ☐ Heavy	Exercise: ☐ None ☐ Light ☐ Moderate ☐ Heavy

Authorization for Release of Information

For consideration which I acknowledge, I grant to Spinal Care Associates the right to use my name, image, video and audio for marketing materials such as, but not limited to, Spinal Care Associates' website, Facebook and Instagram.

☐ Yes ☐ No

Signature: _____ Date:_____

Release of Information

I give Spinal Care Associates permission to talk to the following people about my records/treatment (please print):

Name	Relationship to Patient	Best Contact Number

Patient Signature: _____ Date: _____

Patient Name (Please Print): _____

Family History

Please indicate which conditions exist or have existed by marking the boxes below.

	Self	Mother	Father	Sister	Brother	Son	Daughter
Arthritis	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Blood Disorders	☐	☐	☐	☐	☐	☐	☐
Dementia/Alzheimer's	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Stomach/Intestinal Disorders	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐	☐	☐
Neurological Disorders	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐
Psychological/Mental Disorders	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Other Patient Conditions	☐	☐	☐	☐	☐	☐	☐
Unknown Conditions	☐	☐	☐	☐	☐	☐	☐

Comments/Explanations for any conditions marked above:

Please list any previous surgeries:

Please list your symptoms/pain from WORST to LEAST:

1._____ **4.**_____

2._____ **5.**_____

3._____ **6.**_____

Symptoms/Conditions:

Name: _____ **Date: _____**

Cause of Pain (Example: Fall, Lifting, Gradual Onset, etc.):

Rate your pain when it is at its <u>WORST</u> (1-10, 10 being the worst):

☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10**

Please list any activities impaired by the pain/discomfort (Example: Lifting Children, House Work, Driving, etc.):

Pain Quality:

- ☐ None
- ☐ Aching
- ☐ Burning
- ☐ Cramping
- ☐ Deep
- ☐ Dull
- ☐ Numbness
- ☐ Radiating
  - Where?

  _____
- ☐ Sharp
- ☐ Shooting
- ☐ Stiffness
- ☐ Tightness
- ☐ Tingling

Pain Frequency:

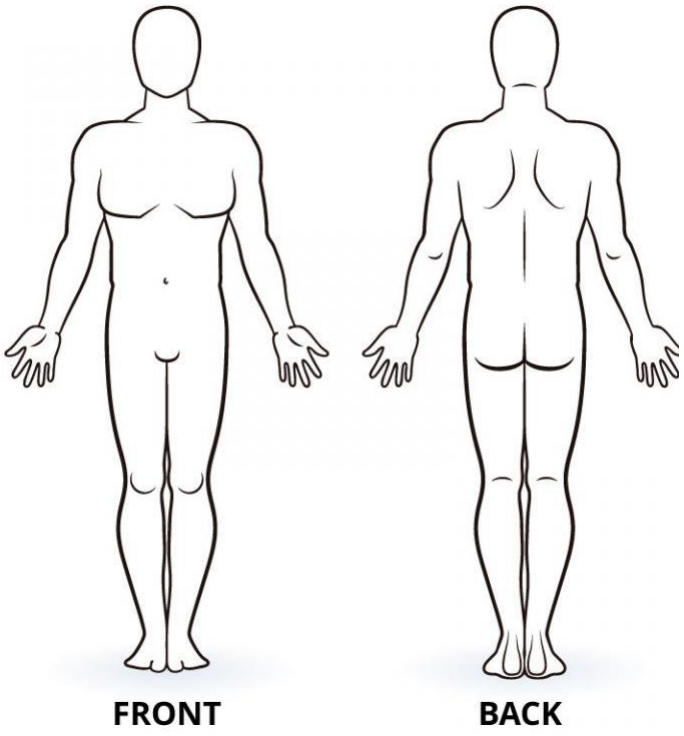
- ☐ Constant
- ☐ Frequent
- ☐ Intermittent
- ☐ Occasional
- ☐ Never

Start of Pain:

_____/_____/_____

Have you had chiropractic care in the past?

☐ Yes ☐ No



Mark any areas of complaint

Pain Aggravated By:

- ☐ Bending
- ☐ Exercising
- ☐ House Work
- ☐ Lifting
- ☐ Lying Down
- ☐ Reaching
- ☐ Sneezing/Coughing
- ☐ Walking
- ☐ Driving
- ☐ Getting up/down
- ☐ Increased Activity
- ☐ Looking Down
- ☐ Overhead Activities
- ☐ Sitting
- ☐ Standing
- ☐ None of the Above

Pain Relieved By:

- ☐ Exercise
- ☐ Ice
- ☐ Lying Down
- ☐ Resting
- ☐ Standing
- ☐ Walking
- ☐ Heat
- ☐ Lifting
- ☐ Medication
- ☐ Sitting
- ☐ Stretching
- ☐ None of the Above

Other comments in regards to your symptoms: