The New Life Chiropractic Center

6550 Mercantile Dr., E, Ste 105 Frederick, MD 21703
301-668-2222

Patient Intake Forms

Patient Info

Name:_____ Preferred Name:_____ Date:_____
Address:_____City:_____State:_____Zip Code:_____
Home Phone:_____ Work:_____ Cell: _____
E-mail:_____ Email will be used for newsletters & updates only.
Social Security Number:_____ Date of Birth:_____ Age:_____ Sex: M F
Occupation:_____ Employer:_____
Height:_____ Weight:_____ Blood Pressure:_____
Race: Asian Black White Ethnicity: Hispanic Not Hispanic
Marital Status: Single Married Separated Divorced Widowed
Spouse's Name: _____ Spouse's Occupation:_____
Do you have children? Y N If yes, how many & what age/s?_____
Emergency Contact:_____ Relationship:_____ Phone #:_____
Referred By:_____ Primary Care Physician:_____

Insurance

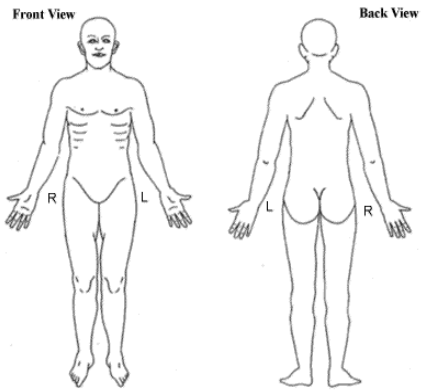
Policy Subscriber:_____ SSN:_____ Relationship to patient:_____
Subscriber's Date of Birth_____
Insurance Company:_____ Subscriber ID:_____ Group #:_____
Is there secondary insurance coverage? Y N If yes, please fill in appropriate information.
Policy Subscriber:_____ _____ SSN:_____ Relationship to patient:_____
Insurance Company:_____ Subscriber ID:_____ Group #:_____
Please present insurance card/s so we can put a copy in your file.

Accident Info

Is your condition due to an accident? Y N If yes, date of incident_____
Type of accident? □ Automobile □ Work □ Employer □ Other_____
To whom have you reported the accident? □ Insurance □ Worker's Comp □ Employer □ Other_____
Insurance Company:_____ Phone #:_____ Claim #:_____
Attorney Name & Phone # (If applicable)_____

Patient Condition

What is your major symptom/problem?_____
When did your symptoms begin?_____
Did it begin: Gradually Suddenly Progressed over time
Have you had this problem before?_____
Is your condition getting progressively worse? Yes No
Is this problem: □ Constant □ Comes and goes
Does it feel? □ Burning □ Sharp □ Shooting □ Dull □Achy □ Stiff
□ Tingling □ Throbbing □ Swelling □
Other_____
Does your pain radiate into your: Arms Hands Legs Feet Head
Circle below the severity of your pain on a scale of 0 to 10:
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)
What makes your condition better?_____
What makes your condition worse?_____



Please mark where it hurts

Does it interfere with your: □ Work □ Sleep □ Daily Routine □ Recreation
Activities/movements that are painful to perform: □ Sitting □ Standing □ Walking □ Bending
□ Lying down □ Reading □ Getting Up □ Reaching

Health History

What other treatments have you had for this condition?
□ Chiropractic □ Orthopedic □ Neurologist □ Physical Therapy □ Medication □ Surgery
Name/s of other doctors who have treated you for this condition:_____
Describe any treatment received:_____
Previous Chiropractic Care? Yes No If yes, what doctor/facility?_____
Have you had any X-rays or MRI's? Yes No If yes, where were they taken?_____
List any medications you are taking:_____
Vitamins/Herbs/Supplements:_____
Females only: Are you Pregnant? Yes No Beginning of last menstrual cycle:_____
Are you Nursing? Yes No

Check any of the following conditions/diseases you have had:

□ AIDS/HIV	□ Epilepsy	□ Osteoporosis
□ Allergies	□ Headaches	□ Poor Circulation
□ Anxiety/Depression	□ Headaches-Migraines	□ Prostate Problems
□ Arm/Shoulder Pain	□ Heart Disease	□ Rheumatoid Arthritis
□ Arthritis	□ Hemorrhoids	□ Sciatica
□ Asthma	□ Herniated Disk	□ Shingles
□ Bladder Problems	□ High Blood Pressure	□ Sinus Infection
□ Cancer	□ Insomnia	□ Stroke
□ Chronic Fatigue	□ Irregular Cycle	□ Swine Flu
□ Deafness	□ Kidney Problems	□ Thyroid Problem
□ Diabetes	□ Leg Pain	□ TMJ
□ Digestive Problems	□ Low Back Pain	□ Venereal Disease
□ Earache	□ MRSA	□ Vertigo/Dizziness
□ Ear Ringing	□ Neck Pain	□ Other:

Stressors		**Exercise**
□ Smoking	Packs/Day_____	□ None
□ Alcohol	Drinks/Week_____	□ Moderate
□ Coffee/Caffeine Drinks	Cups/Day_____	□ Daily
□ High Stress Level	Reason_____	□ Heavy

Have you had any?

	Description	**Date**
Automobile Accidents	_____	
Surgeries	_____	
Broken Bones	_____	
Falls/Head Injuries	_____	

Authorization

Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorized The New Life Chiropractic Center & Dr. Steven Digles D.C. to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Signature Date Parent (if patient is a minor)

HEALTH CARE AUTHORIZATION FORM

Patient's Name_____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES ***THE NEW LIFE CHIROPRACTIC CENTER*** TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- I give permission to The New Life Chiropractic Center (NLCC) to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday and holiday related cards, information about treatment alternatives, and other health related information.
- If NLCC contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give NLCC permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, he will provide a room for these conversations.
- By signing this form you are giving NLCC permission to use and disclose your protected health information in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this authorization, in writing only, at any time. However your written request to revoke this authorization is not effective to the extent that we have provided services or take action in reliance on your authorization.

You may revoke this authorization by mailing or hand delivering a written notice the Privacy Official of The New Life Chiropractic Center. The written notice must contain the following information:

- Your name, date of birth, and social security number
- A clear statement of your intent to revoke this authorization
- The date of your request and your signature

The revocation is not effective until received by the Privacy Official.

A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU IF REQUESTED.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a *Notice of Information Practices* that provided a more complete description of information uses and disclosures. I understand that I have the following rights and privileges: the right to review the notice prior to signing this consent, the right to object to the use of my health information for directory purposes, and the right to request restrictions as to how my health information may be used of disclosed to carry out treatment, payment, or health care operations.

Patient Signature:_____ Date:_____

Parent/Guardian Signature (if patient is a minor)

The New Life Chiropractic Center

Experience New Health, Hope, and Life

Patient Policies

Payment Policies
We do everything possible to significantly minimize the cost of your care. We have found the administrative expense of billing patients increases our overhead, and you can help us keep your cost down by eliminating the need for us to bill you. The following is summary of our payment policy.

All payment is expected at the time of service/check-in
Payment is expected at time of check-in unless you are on a payment plan. This includes applicable co-insurance, estimated co-insurance and co-payments for participating insurance companies. We accept cash, personal checks, Visa, MasterCard and Discover.

Payment Options
We can make our care affordable to most everyone due to our different payment options. We have searched far and wide for a health financing company that accepts most everyone who needs care. By having this connection we can work with you if you need different payment options.

Insurance
We bill participating insurance companies as a courtesy to you. In our experience, we have learned that many insurance companies are scoundrels. Sometimes they delay payment, deny services and in general make life difficult. We will do our best to try to help you in this process. If we have not received payment from your insurance company in a timely manner (45-60 days), you are expected to pay your balance in full. You are ultimately responsible for all charges.

Questions
If you need any help or have questions, please call our office between 9:00 a.m.-5:00 p.m., Monday through Thursday at 301.668.2222.

Missed Appointments /Untimely Cancellations
Please give 24-hours notice if you have to miss an appointment. We understand this is not always possible. We will work with you, but if you make a habit of missing appointments, we reserve the right to charge for missed or untimely cancelled appointments.

- ❖ I have read the above information, understand it and will abide by it.

Patient Name:_____ Date:_____

Office Staff:_____ Date:_____

The New Life Chiropractic Center

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Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Vs. Probable Risks:

Possible Risks : As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at 1 in 1,000,000 to 1 in 5,000,000 and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical Care,* typically anti-inflammatory drugs, tranquillizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me. I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

PRINTED NAME	SIGNATURE	DATE
WITNESS NAME	WITNESS SIGNATURE	DATE

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