Barnes CHIROPRACTIC
MOVE WELL | FEEL WELL | LIVE WELL

New Patient Intake

Patient Information

Name:_____ Birthdate: _____/_____/_____

Home Address:_____ Age:_____ Gender:_____

City, State, Zip: _____ Marital Status: S M W D

Phone: ( )_____ Email:_____

Is it okay if we communicate via phone, text, and email messaging concerning your care and appointments? ☐ Yes ☐ No

Employer:_____ Occupation:_____

How were you referred to this office?:_____

Primary Care Physician: _____ Date of Last Visit: ____/_____/____

Reason for visit:_____

When doctors work together it benefits you. May we have your permission to update your PCP regarding your care at this office? ☐ Yes ☐ No

Emergency Contact: _____ Phone: _____

Purpose for this Visit

Reason for this visit: _____

Is this related to an accident or specific injury (other than auto or work-related)? ☐ Yes ☐ No

Describe incident or reason for onset of symptoms: _____

_____

Have you been treated for this previously? ☐ Yes ☐ No When was the last treatment: ____/_____/____

Name of treating practitioner/facility: _____

What treatment(s) was performed?: _____

How did you respond to this treatment?: _____

Medications prescribed/taking for this condition: _____

Current Health Information

Please list all symptoms that you are experiencing today.

1) Symptom: _____ Onset Date: _____

Is it getting progressively worse: ☐ Yes ☐ No ☐ Constant ☐ Comes and Goes

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ School

Explain: _____

_____

Rate your level of pain: No pain = 0 1 2 3 4 5 6 7 8 9 10 = Extreme Pain

Frequency of pain: ☐ Daily ☐ Weekly / ☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant

What makes it feel better? _____

What makes it feel worse? _____

2) Symptom: _____ Onset Date: _____

Is it getting progressively worse: ☐ Yes ☐ No ☐ Constant ☐ Comes and Goes

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ School

Explain: _____

_____

Rate your level of pain: No pain = 0 1 2 3 4 5 6 7 8 9 10 = Extreme Pain

Frequency of pain: ☐ Daily ☐ Weekly / ☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant

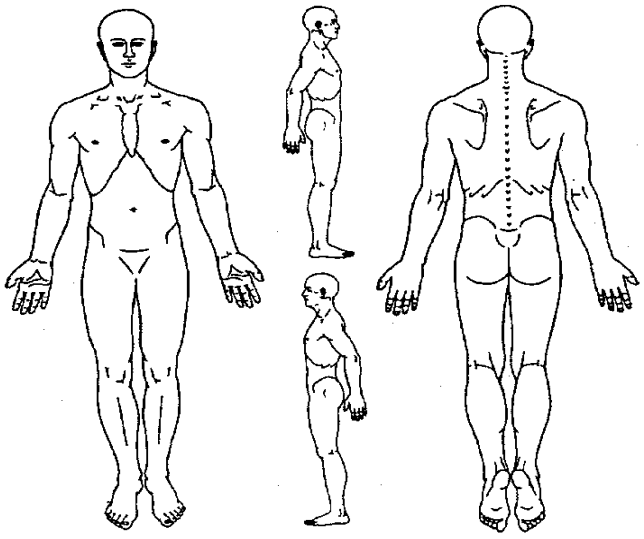
What makes it feel better? _____

What makes it feel worse? _____

Pain Diagram

On the following diagram, please indicate all areas of

Pain – XXX Stiffness - /// Numbness – OOO Other - _____



Current Health Information

Please list any additional symptoms you are currently experiencing, even if you feel they do not relate to your spine or chief complaint:

_____

_____

_____

Health conditions you are currently being managed/treated for:

_____

_____

_____

Current medications and Supplements (include name and for what condition):

_____

_____

Previous Health History

List any surgeries and date: _____

_____

List any major trauma / accidents / injuries and date: _____

_____

List any major illness or health condition and date: _____

_____

Have you seen a Chiropractor before: ☐ Yes ☐ No Who? _____

Reason for visit(s):_____

Family Healthy History

Do you have a family history of Cancer, Heart disease, Diabetes, Auto-immune Conditions or Arthritis?
(If yes, please list family member, age, and condition of disease.)

_____

_____

Insurance

Barnes Chiropractic is a participating network member for Excellus Blue Cross Blue Shield, Blue Cross Blue Shield Blue Card Program, Aetna, Landmark, and Medicare. Each individual plan for these companies is different and may or may not include Chiropractic coverage; your insurance policy may have limitations, deductibles, co-payments or may not cover certain services. Every effort will be made by our office to verify your insurance benefits and confirm the details of coverage; however, as stated by the insurance companies, verification is never a guarantee of coverage and this may change at any time without the insurance company notifying our office or you of this change at the time it occurs. Your insurance plan is a contract between you and your insurance company. This clinic is not party to that contract and therefore cannot modify the terms of that contract.

Insurance Carrier: _____ Member ID: _____

Name of Subscriber: _____ Date of Birth: _____/_____/_____

Payment Policy

Payment for treatment you receive at Barnes Chiropractic is your responsibility whether your insurance company pays or not. Payment is expected at the time services are rendered; detailed receipts are available upon request. If your insurance company denies your claim, you will be responsible for the balance. This office accepts all major credit cards, debit cards for health savings and flex spending accounts, personal checks, and cash. Any checks returned for insufficient funds will be charged a $37.00 fee. Any unpaid, unresolved balances will be forwarded to our collection agency after 60 days.

Assignment of Benefits

I authorize payment of insurance benefits directly to Alicia L Barnes, DC, CCSP or Barnes Chiropractic. I authorize the release of any information pertinent to my case to any insurance company, adjustor, or healthcare providers to secure payment of benefits. My signature below is a direct assignment of my rights and benefits under this policy.

HIPAA / Notice of Privacy Practices Acknowledgement

I understand that I have certain right or privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used for the purpose of treatment, payment, healthcare operations, and coordination of care. If you would like a more detailed account of your privacy rights as a patient, a HIPAA notice is available to you at the front desk. If there is anyone you do not want to receive your medical records, please inform our office.

Appointments, Scheduling, and Cancellation Policy

As a courtesy to all our patients, we strive to maintain a smooth and time efficient practice while addressing our patient's individual healthcare needs. As a patient of this practice you agree to keep all your scheduled appointments. If for some reason you need to cancel or reschedule your appointment, 24-hour notice is required (email and voicemail messages are acceptable forms of cancellation). Missed appointments or cancelling outside the 24-hour period will result in a $25.00 fee not coverable by insurance.

Please sign your name and date below to acknowledge that you have read, understand, and agree to Barnes Chiropractic's Insurance and Payment Information, Assignment of Benefits, Notice of Privacy Practices, and Appointments and Cancellation Policies.

Patient Signature: _____ Date: _____/_____/_____