Chiropractic Orthospinology

New Patient Intake Form

PATIENT DETAILS

Today's Date			Nickname		
Last Name / First / MI			Sex □ Male □ Female	Birth Date	Age
Address / Apt# / City / State / Zip					
Cell Phone #	Secondary Phone #		Social Security #		
Appt Reminder Preference □ Text □ Email □ None	Cell Phone Provider		Personal Email		
Married Status □ Single □ Married □ Divorce			Parent Name (for minor patients only)		
Emergency Contact	Relationship		Phone #		
Employer Name			Job Title		

CONDITION

Reason for Visit	
When did your symptoms appear?	Is this condition getting progressively worse? □Yes □ No □ Unsure
Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain)	Frequency of Pain
Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting □ Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Other	Is it Constant or does it Come and Go
Does it interfere with your: □ Work □ Sleep □ Daily Routine □ Recreation	
Activities or movements that are painful to perform: □ Sitting □ Standing □ Walking □ Bending □ Lying Down	
Mark an X on the picture where you continue to have pain, numbness or tingling:	

HEALTH HISTORY

What treatment have you already received for your condition?

 Medications Surgery Physical Therapy Chiropractic Services None Other ____________________

Place a mark on “yes” or “no” to indicate if you have had any of the following:

Condition	Yes/No	Condition	Yes/No	Condition	Yes/No
AIDS/HIV	Yes No	Goiter	Yes No	Pinched Nerve	Yes No
Alcoholism	Yes No	Gonorrhea	Yes No	Pneumonia	Yes No
Allergy Shots	Yes No	Gout	Yes No	Polio	Yes No
Anemia	Yes No	Heart Disease	Yes No	Prostate Problem	Yes No
Anorexia	Yes No	Hepatitis	Yes No	Prosthesis	Yes No
Appendicitis	Yes No	Hernia	Yes No	Psychiatric Care	Yes No
Arthritis	Yes No	Herniated Disk	Yes No	Rheumatoid Arthritis	Yes No
Asthma	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Bleeding Disorders	Yes No	High Blood Pressure	Yes No	Scarlet Fever	Yes No
Breast Lump	Yes No	High Cholesterol	Yes No	STD	Yes No
Bronchitis	Yes No	Kidney Disease	Yes No	Stroke	Yes No
Bulimia	Yes No	Liver Disease	Yes No	Suicide Attempt	Yes No
Cancer	Yes No	Measles	Yes No	Thyroid Problems	Yes No
Cataracts	Yes No	Migraine Headaches	Yes No	Tonsillitis	Yes No
Chemical Dependency	Yes No	Miscarriage	Yes No	Tuberculosis	Yes No
Chicken Pox	Yes No	Mononucleosis	Yes No	Tumors, Growths	Yes No
Diabetes	Yes No	Multiple Sclerosis	Yes No	Typhoid Fever	Yes No
Emphysema	Yes No	Mumps	Yes No	Ulcers	Yes No
Epilepsy	Yes No	Osteoporosis	Yes No	Vaginal Infections	Yes No
Fractures	Yes No	Pacemaker	Yes No	Whopping Cough	Yes No
Glaucoma	Yes No	Parkinson’s Disease	Yes No	**Other:**	

OFFICE FINANCIAL POLICY

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.
2. Low Country Clinic, Inc. may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.
3. If you need to reschedule an appointment you must notify Low Country Clinic, Inc. 24 hours in advance. Additionally, if you miss an appointment you must call within 24 hours and/or make it up within 7 days. Failure to comply with the above-mentioned scenarios will result in a $25 fee. You yourself are responsible for this fee as no insurance, lien, etc. will pay for this. The fee is due upon your immediate next visit or two days later (whichever comes first).
4. All payments made to the Low Country Clinic, Inc. for insufficient funds will be charged a $30.00 processing fee regardless of amount. Thereafter acceptable payment will be cash or credit card only.
5. If you have insurance, Low Country Clinic, Inc. will gladly accept assignment with the following exceptions and regulations, provided we have prior certification from your insurance company.
6. Low Country Clinic, Inc. accepts assignment for the initial treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment per visit.
7. Low Country Clinic, Inc. accepts assignment as a courtesy to you; you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.
8. Whenever you receive any worksheets from your insurance company or explanation of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine whether proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue you an overpayment check-it will not come from your insurance company. All

insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.

9. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.
10. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.
11. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payment in full expected immediately; regardless of any claims submitted.
12. If you have questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the Doctor.
13. Any accounts that become overdue 90 Days or more will be subject to a 35% fee and will be referred to a third party collection agency.

I have read and understand this Financial Office Policy and agree to abide by all terms.

______________________________ ______________________________

Patient's Signature Date

I understand and agree that all fees associated with my first visit to this office, including but not limited to, exam and all necessary x-rays, will be billed to my insurance company regardless of any discount I receive for the first visit.

______________________________ ______________________________

Patient's Signature Date

CONSENT FOR TREATMENT AND AUTHORIZATION TO PERFORM X-RAYS

I authorize Dr. Bryan Aldrich to perform a radiographic examination if the Doctor deems necessary to diagnose and to administer whatever examination or treatment is deemed necessary to treat my present problem (or illness).

To the best of my knowledge I am NOT pregnant and the above named Doctor has my permission to x-ray me for diagnostic interpretation.

______________________________________ _________________

Patient's Signature Date

HIPAA PRIVACY POLICY
CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to/for:

- Carry out treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (i.e. my insurance company)
- The day to day healthcare operation of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at anytime to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

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

_______________________________________ __________________

Patient’s Signature Date

AUTHORIZATION, ASSIGNMENT & RELEASE FORM

In consideration of your undertaking of care from Low Country Clinic, Inc., I agree to the following:

1. Low Country Clinic and/or Dr. Bryan S. Aldrich is authorized to release any information deemed appropriate and necessary concerning my physical condition to any insurance company or adjuster to process any claim for reimbursement of charges I incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney (personal injury cases) , from the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you, based in whole or in part upon the charges made for your services.
3. In the event any insurance company is obligated to make payment to me or to you for the charges made for your services, refuse to make such payment upon demand by you; I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute and take action in my name as you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance companies' proceeds, whether it is all or part of what is due, I personally owe and agree to pay you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in the State of South Carolina.
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization and Assignment will be in continual effort until revoked by both parties.

_____________________________ _________________________

Patient's Signature Date