EKLUND CHIROPRACTIC

INTAKE FORM

Today's Date (MM/DD/YY)

Gender
◯ Male ◯ Female

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (Or Initial)

Birth Date (MM/DD/YYYY)

Height

Address

Marital Status
◯ Single ◯ Married
◯ Divorced
◯ Widowed ◯ Separated

Weight

City

State

ZIP/Postal Code

Home Phone

Cell Phone

Spouse's Name

Spouse's Birth Date

E-Mail Address

Child's Name & Age

Emergency Contact

Phone

Child's Name & Age

Your Occupation

Your Employer

Child's Name & Age

Primary Physician

Who can we thank for referring you:

How can we help you today?

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ **I have read and reviewed the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials _____ **Would you like an appointment reminder? YES NO**

Initials _____ **If yes: Circle which you prefer for future appointments: TEXT REMINDERS EMAILS NONE**

Initials _____ **If text: Circle your cell phone provider: Verizon AT&T T-Mobile Sprint Other:**_____

Initials _____ **I grant permission to be called or text to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in the office.**

Initials _____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials _____ **I may request a copy of the Financial Policy at any time.**

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature

Date (MM/DD/YYYY)

If the patient is a minor child, print child's full name: _____

I hereby request and consent to the performance of procedures, including various modes of physio therapy,

CONFIDENTIAL HEALTH INFORMATION

INFORMED CONSENT TO TREAT/ HIPPA

chiropractic adjustments, examinations, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by *Clinic* and/or other licensed providers and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up providers named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to : conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificated. I have read and understand your Notice if Privacy Practices. A more completed description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and disclosed.

I understand and I am informed that, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all healthcare treatments, there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the *Clinic* provider to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I further understand that treatment is designed to improve health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued.

I further understand that there are treatment options available for my condition, these treatment options include, but limited to self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other options if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient:_____ Date:_____

Signature of Patient:_____

Name Printed of Guardian/Parental and Relationship to Patient:_____

Guardian/Parental Signature:_____ Date:_____