ELEVATED
HEALTH CENTER

ADULT INTAKE FORM

Date: _____

PERSONAL INFORMATION

First Name: _____ M.I.: _____ Last Name: _____

Preferred Name: _____ Social Security Number: _____

Address: _____

City / State / Zip: _____

Cell Phone: ( ) _____ Alternate Phone: ( ) _____

Text Reminders: Y N Before Appointment: 1 hr 4 hrs 1 day Cell Provider: _____

Email: _____ *(For updates on office hours, events, etc.)*

Birth Date: _____ Age: _____ Sex: M F

Occupation: _____ Employer's Name: _____

Marital Status: S M D W Other Spouse's Name: _____

# of Children: _____

Children's Names & Ages: _____

Who can we thank for referring you or how did you hear about Elevated? _____

_____

REASON FOR SEEKING CARE

What is your reason for seeking care at Elevated Health Center? _____

_____

When did this begin? (If applicable) _____

Are there any major injuries and/or surgeries we should know about? _____

_____

What is this affecting that is MOST important in your life? (List all that apply)

_____

Have you seen any other providers for this condition? (List all that apply)

_____

Have you seen a chiropractor before? Yes No

How long ago? _____ Clinic/Doctor Name: _____

What is your reason for the change? (If applicable) _____

What is your level of commitment to yourself and your health? 1 2 3 4 5 6 7 8 9 10

Explain: _____

What health goal, if you were to complete or accomplish it, would have the greatest impact on your life?

_____

_____

HEALTH CONCERNS

- ☐ Anxiety/Depression
- ☐ Digestive Troubles
- ☐ Nausea/Vomiting
- ☐ Diabetes
- ☐ Hypertension
- ☐ Arthritis
- ☐ Loss of Balance
- ☐ Neck/Back Pain
- ☐ Pain in Arms/Legs
- ☐ Irritabilty
- ☐ Fatigue/Sleep Issues
- ☐ Dizziness
- ☐ Ringing in Ears
- ☐ Sensitivity to Light
- ☐ Loss of Concentration
- ☐ Memory Problems
- ☐ Headaches
- ☐ Stiffness/Flexibility
- ☐ Sinus Troubles/Allergies
- ☐ Cold Hands/Feet
- ☐ Other _____

Explain any boxes checked above or add additional concerns:

_____

_____

_____

_____

_____

Is there anything else regarding your current condition you feel the doctor should know?_____

_____

_____

MEDICATIONS

- ☐ Anxiety/Depression
- ☐ Blood Pressure
- ☐ Pain Narcotics
- ☐ Muscle Relaxers
- ☐ Migraine/Headache
- ☐ Cholesterol
- ☐ ADD/ADHD
- ☐ Diabetes
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Explain any boxes checked above: _____

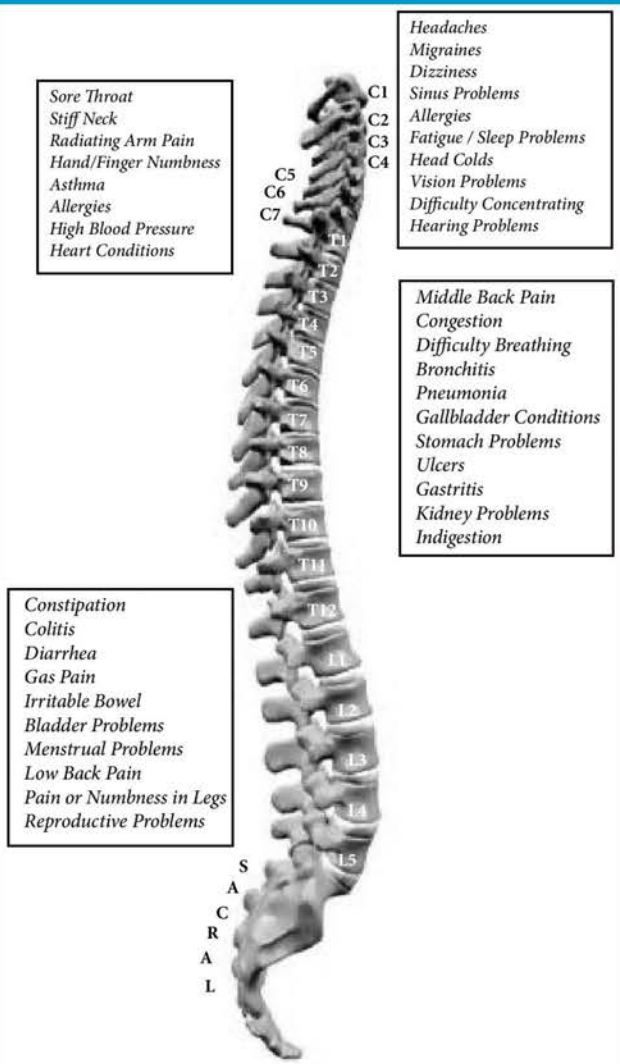
_____

_____

_____

Did You Know....

Each health concern relates to a specific area of the spine and nervous system? Please circle below or enter the information to the left.



VITAMINS / SUPPLEMENTS

- ☐ Multi-Vitamin
- ☐ Vitamin D3
- ☐ _____
- ☐ _____
- ☐ Fish Oil/Omega-3
- ☐ Probiotics
- ☐ _____
- ☐ _____

Explain any boxes checked above:

_____

_____

_____

EMERGENCY CONTACT

First Name: _____ M.I.: _____

Last Name: _____

Preferred Name: _____

Address:_____

City / State / Zip: _____

Phone: ( ) _____Relation: _____

STRESS QUESTIONNAIRE

Most life stresses can be grouped into 3 main categories: Physical, Chemical, and Emotional Stress.
Please check any of the following stresses you experience on a regular basis.

Physical Stress

☐ Physical Pain ☐ Low Energy/Fatigue ☐ Job/Hobbies Cause Discomfort ☐ Tightness/Stiffness
☐ History of Accidents/Injuries ☐ Inability to Exercise/Perform Physical Activities ☐ Other _____
Explain: _____

Chemical Stress

☐ Fast Food/Highly Processed Food ☐ Medications (Prescription or OTC) ☐ Consume Alcohol ☐ Tobacco
☐ Amalgam Fillings ☐ Makeup/Lotion/Other Skin Products ☐ Other _____
Explain: _____

Emotional Stress

☐ Work/Job ☐ School ☐ Health ☐ Finances ☐ Family ☐ Daily Schedule/Time ☐ Other _____
Explain: _____

What else about your health or your life do you feel is important for the doctor to know?

_____

ADVANCED BENEFICIARY NOTICE (ABN)

The purpose of this section is to help you be aware of chiropractic services in this office as it relates to any medical insurance you may have. Chiropractic care in this office is not focused on diagnosis of or relief of symptoms; it is centered on the location, analysis, and correction of underlying vertebral subluxations. Because of this, most services are coded in a manner which insurance carriers view as maintenance or wellness care and most likely will not be covered. Signing below signifies that you want the services provided in this office, but understand that not all the care is covered by your insurance company and therefore, not billed to them. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they do not meet the criteria laid out by your insurance company. This notice gives our opinion and policies as it relates to insurance coverage, not an official Medicare or other insurance carrier's stance or decision. Signing below indicates you have receive and understand this notice.

Name (Printed): _____
Signed: _____ Date: _____
Parent/Guardian Signature (if applicable) _____

For Office Use Only

ID#: _____ I: _____
Scans: _____ R: _____
ROF: _____ O: _____
Other _____

PATIENT HIPAA CONSENT FORM

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view charges to your records. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 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 certificates. I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and disclosed.

Date: _____ Print Patient Name: _____

Signature: _____ Relationship to Patient : _____

FINANCIAL POLICY

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

- We urge our patients to follow the doctor's recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, care must be followed.
- I authorize Elevated Health Center to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me.
- I authorize the direct payment to Elevated Health Center of any sum I now or hereafter owe by my attorney out of settlement of my case, and by any insurance company obligated to make payment to me or Elevated Health Center based in whole or in part upon the charges made for services received. I hereby appoint Elevated Health Center authority to endorse and cash checks, drafts, or money orders made payable to the undersigned or as co-payee with this clinic for payments due for services rendered on behalf of the undersigned by Elevated Health Center.
- In order to file your claims in a timely manner, we need current, accurate insurance information for you and your dependents. We will do our best to confirm your eligibility and level of insurance coverage for care; however, it is ultimately your responsibility to know your own insurance benefits in relation to what your insurance covers and what it doesn't. Should your insurance carrier determine that any or all of our services are ineligible for payment, you will be billed directly for those services.
- Insurances: With the recent health care changes, high deductible plans are more common place. As a result, charges for chiropractic care offered at Elevated Health Center will be collected in full at the time of visit, based on the contracted amounts dependent on each insurance company. This high deductible balance will not be allowed to exceed $100.00. Co payments are due at the time of service. If the balance is not pain in full within 30 days, any outstanding balance will accrue at a rate of 1.75% per month (21% annually), which will be added monthly to that account. Failure to settle a balance for more than 90 days may result in the patient account being turned over to a collections agency.
- If you have any questions about our financial policies, please ask to speak to our financial officer. If you need to make special arrangements, please ask. We will never deny care to anyone based solely on ability to pay. We will do everything possible to meet your financial needs.

Date: _____ Signature: _____

AUTHORIZATION FOR CARE

I hereby authorize doctors and staff at Elevated Health Center to treat my condition as deemed appropriate. At Elevated Health Center we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctor/clinic will not be held responsible for any pre-existing medical conditions. I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Elevated Health Center responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Date: _____ Signature: _____