Owner Landon Taylor D.C.
Sarah Horsley D.C

Georgetown Family Chiropractic

Patient Intake/History Form

How did you hear about our office? (please check one)

Internet _____Another Patient _____Advertising/Event /Mailer_____

Demographic Information

First Name:_____Last Name:_____Middle Initial:____

Address:_____

City:_____ State:_____ Zip:_____

Date of Birth:_____ Social Security No:_____

Gender: (Circle one) Male Female Race: (Circle one) White Black/African American Hispanic Other

Marital Status: (Circle One) Single Married Divorced Other Preferred Language:_____

Contact Information

Primary Number:_____Email:_____

Best Contact Method:_____

Emergency Contact Name:_____ Emergency Contact Number: _____

Employment Information

Employer's Name_____ Employer's City:_____ State:_____

Other Health Care Providers/Family Doctor

Doctor/Provider's Name:_____

Type of Doctor/Provider:_____

May we contact your family physician to discuss your condition/case? Yes / No

Medications

Name and Purpose (if known)_____

_____

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Personal Medical History

Surgeries: (Please list surgery and date to the best of your knowledge)_____

_____

_____

Allergies: _____

Family Medical History: (please circle if your immediate family suffers from any of these conditions)

Diabetes Heart Disease Stroke Cancer Genetic Condition: _____

If female, to the best of your knowledge are you currently or possibly pregnant?_____

Social History

Do you smoke: _____ If you quit, how long since quitting in years_____

How would you rate you physical fitness from 0-10, with 10 being very fit and 0 being extremely unfit: _____

How would you rate your diet from 0-10, with 10 being very healthy and being extremely unhealthy: _____

How many glasses/bottles of water do you consume daily on average: _____

How many caffeinated beverages do you consume daily on average: _____

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Review of Body Systems
Do you have or have you had any of the following conditions?

Musculoskeletal : (circle any that apply)

Osteoporosis Scoliosis Back Problems Neck Problems Shoulder problems Elbow/Wrist problems

Hip problems Knee problems Foot problems TMJ problems

Neurological: (circle any that apply)

Headaches Dizziness Numbness/Tingling Anxiety Depression

Cardiovascular: (circle any that apply)

Heart attack Stroke High Blood pressure High Cholesterol Angina/Chest Pain Poor Circulation

Respiratory: (circle any that apply)

Asthma Emphysema Shortness of Breath Sleep Apnea Pneumonia

Digestive: (circle any that apply)

Heartburn Ulcer Diarrhea Constipation Anorexia/Bulimia

Sensory: (circle any that apply)

Blurred Vision Hearing loss Loss of Smell Ringing in Ears Loss of Taste

Integumentary: (circle any that apply)

Skin Cancer Eczema Psoriasis Rash

Endocrine: (circle any that apply)

Diabetes Thyroid Conditions Chronic Low Energy Immune Disorders Frequent Infections

Genitourinary: (circle any that apply)

Kidney Stones Prostate Issues Reproductive Issues Pain during urination

Constitutional: (circle any that apply)

Poor appetite Sudden weight gain or loss Chronic Fatigue Weakness Fainting

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Please answer all questions completely

Please explain in detail how your accident happened:

_____

_____

_____

_____

_____

What were the time and date of present injury?

_____

Where did you feel pain immediately after the accident?

_____

Symptoms since the accident/chief complaint today:

_____

_____

_____

Where were you taken after the accident?

_____

Hospitalized? ☐ Yes ☐ No **If yes, admitted**? _____ **How long**? _____

Name of Hospital:

_____

Name of Doctor(s):

_____

What treatment was given?

_____

Was any other doctor consulted after your accident? ☐ Yes ☐ No

If so, what was the doctor's name? _____ D.C., M.D., D.O., D.D.S.

Did they do any imaging(X-rays, CT, MRI)?

_____

What treatment was given?

_____

How often did you see the doctor?

_____

Have you ever had any complaints in the involved area before? ☐ Yes ☐ No

If so, what were the complaints?

_____

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Since this injury are your symptoms … ☐ Improving? ☐ Getting worse? ☐ Same?

Driver of vehicle in which you were injured (if applicable):

Name _____ Insurance Company _____ Policy No. _____

Have you retained an attorney? ☐ Yes ☐ No
If so, his/her name and address _____

Were police notified? ☐ Yes ☐ No

Were you knocked unconscious? ☐ Yes ☐ No **If yes, for how long?**

_____

You were struck from Behind/ Front/ Left Side/ Right Side

_____

You were Driver/ Passenger/ Front seat/ Back Seat

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

Did the airbags deploy? ☐ Yes ☐ No

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ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE PERSONAL INJURY, WORK COMP, ERISA, AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, any and all medical benefits and/or any insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of all medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient Signature_____

Date_____

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Informed Consent

Patient Name: _____

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:
Spinal manipulative therapy, palpation, taking of vital signs, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis testing, ultrasound, hot/cold therapy, electric muscle stimulation, spinal rehabilitation exercises, and radiographic studies.
Note: You will only receive what the Doctor prescribes as necessary to treat your condition.

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and /or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest.
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize Georgetown Family Chiropractic to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: _____.
This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.
As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment.
By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that itis in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient's Name: _____ Date: _____

Patient's Signature: _____

Signature of Parent or Guardian (if a minor) _____

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PRIVACY POLICY

Our office policy of privacy practices outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services:

1. The patient understands and agrees to all this office to use their PHI for the purpose of treatment, payment, health care operations, and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligation: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.
7. A copy of this policy will be available upon request and is also posted in the waiting room area of our office located at 100 Eastside Drive, Georgetown, KY 40324.

Patient Name (printed): _____

Patient Signature: _____ Date:_____

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FINANCIAL POLICY

Welcome to Georgetown Family Chiropractic! We are delighted that you chose our office to care for you. Our goal is to treat patients of all ages with different needs and we use our best efforts to make your experience as pleasant as possible. Please be aware that even if you have insurance, your account is your responsibility, NOT that of your insurance company. Before or during your initial visit, we contact your insurance company to get benefit information. The representative or online system immediately reads us a disclaimer that states they do not guarantee payment and that payment is based on the plan booklet that you received. We urge you to be fully aware of the provisions of your policy, as we are NOT responsible for any errors, omissions or misinformation given to us by your insurance company. Although we do our best to provide the most accurate information to you, it is possible you may owe money after your insurance has paid. We ask the balance be paid upon receipt of your billing statement.

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies:

Our clinic has established a single fee schedule that applies to all patients for each service provided and you may receive a copy of this fee schedule upon request.

You may be entitled to a network or contractual discount under the following circumstances:

- If we are a participating provider in your health plan.
- If you are covered by a State or Federal program with a mandated fee schedule.
- If you are a member of DMPO we may join. Patients who are uninsured, or underinsured (limited benefits for chiropractic care), will be entitled to network discounts similar to our insured patients. Membership is $49.00 a year and covers you and your dependents. Ask our team for more information.
- Patients who meet state and or federal poverty guidelines or other special circumstances outlined in our “Hardship Policy” may be offered a discount for a period of time as determined by the clinic. Verification will be required.

As part of our compliance plan, our office will be unable to extend any type of discounts other than those listed above.

Acknowledge below that: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be due and payable.

Acknowledged By: _____

Date: _____