Patient Information Intake

In order to provide you the best possible holistic care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

Name _____ Date _____ Referred by _____

Mailing address

Address _____ City _____ State ___ Zip _____

Telephone (work) _____ (home) _____ E-mail _____

Age _____ Birth date _____ Social Security # _____ Number of children _____

Occupation _____ Employer _____

Marital Status _____ Spouse's name _____ Spouse's Occupation _____

Spouse's employer _____ Spouse's health status _____

Emergency contact _____ Phone _____

Current Complaints

Nature of injury: Automobile* ☐ Work ☐ Other ☐

Please describe _____

_____

_ Date of injury _____ Date symptoms appeared _____

Have you ever had same condition? ☐ No ☐ Yes If yes, when? _____

List other practitioners seen for this injury/condition _____

Have you ever seen a Chiropractor? ☐ No ☐ Yes , Acupuncturist? ☐ No ☐ Yes , Rolfer? ☐ No ☐ Yes

If yes, please describe _____

Insurance Information

Name of party responsible for payment _____ Phone _____

Do you have health insurance? ☐ No ☐ Yes Name of company _____

** If an auto accident please provide:*

Insurance company name _____ Contact person _____

Phone _____ Claim # _____

Billing Address

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

Medical History

Have you been treated for any conditions in the last year? ☐ No ☐ Yes

If yes, please describe _____

Date of last physical exam _____ Is there a chance that you are pregnant? ☐ No ☐ Yes

Have you had X-rays taken? ☐ No ☐ Yes If yes, where? _____

What medications are you taking and for what conditions (Please list dosage and amounts, etc). _____

_____

_____

What vitamins, minerals, or herbs do you currently take? (Please list for what condition, dosage, and frequency).

_____

_____

Have you ever:	No	Yes	Briefly Explain
Broken bones?	☐	☐	_____
Been hospitalized?	☐	☐	_____
Been in an auto accident?	☐	☐	_____
Had Sprains/Strains?	☐	☐	_____
Been struck unconscious?	☐	☐	_____
Had surgery?	☐	☐	_____

Family History

Family Member	Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Habits:	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugary Foods	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

	Yes	No
Do you experience pain every day?	☐	☐
Do your symptoms interfere with daily life?	☐	☐
Does pain wake you up at night?	☐	☐
Are your symptoms worse during certain times of the day?	☐	☐
Do changes in weather affect your symptoms?	☐	☐
Do you wear orthotics?	☐	☐
Do you take vitamin supplements?	☐	☐

What activities aggravate your symptoms?

_____

_____

_____

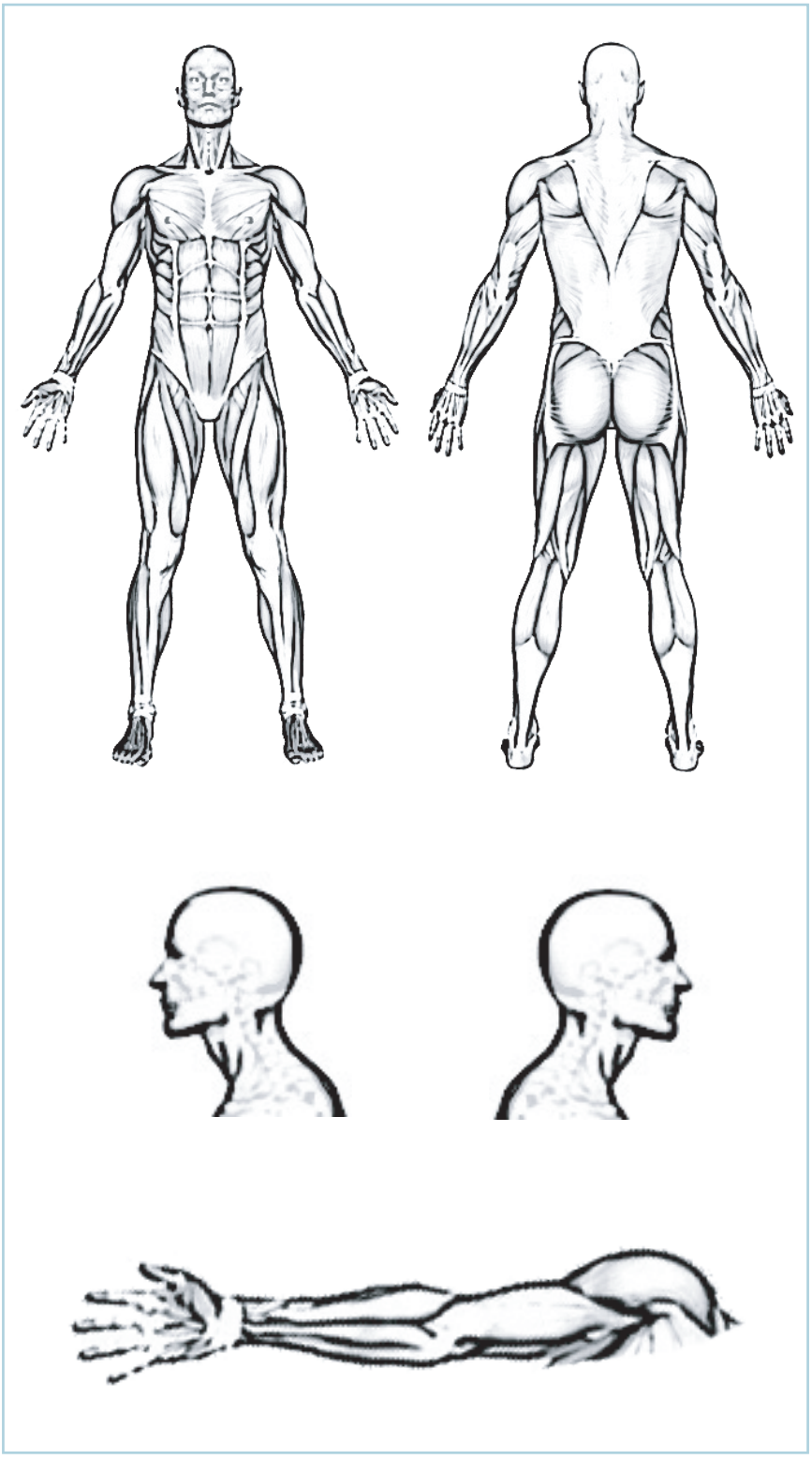
Have you ever suffered from:

- Alcoholism ☐
- Allergies ☐
- Anemia ☐
- Arteriosclerosis ☐
- Arthritis ☐
- Asthma ☐
- Back Pain ☐
- Breast lump ☐
- Bronchitis ☐
- Bruise Easily ☐
- Cancer ☐
- Chest Pain/Conditions ☐
- Cold extremities ☐
- Constipation ☐
- Cramps ☐
- Depression ☐
- Diabetes ☐
- Digestion Problems ☐
- Dizziness ☐
- Ears Ring ☐
- Excessive Menstruation ☐
- Eye Pain/Difficulties ☐
- Fatigue ☐
- Frequent Urination ☐
- Headache ☐
- Hemorrhoids ☐
- High Blood Pressure ☐
- Hot Flashes ☐
- Irregular Heart Beat ☐
- Irregular Cycle ☐
- Kidney Infection ☐
- Kidney Stones ☐
- Loss of memory ☐
- Loss of balance ☐
- Loss of smell ☐
- Loss of taste ☐
- Lumps In Breast ☐
- Neck Pain or Stiffness ☐
- Nervousness ☐
- Nosebleeds ☐
- Pacemaker ☐
- Polio ☐
- Poor Posture ☐
- Prostate Trouble ☐
- Sciatica ☐
- Shortness of breath ☐
- Sinus Infection ☐
- Sleep problems/insomnia ☐
- Spinal Curvatures ☐
- Stroke ☐
- Swelling of ankles ☐
- Swollen Joints ☐
- Thyroid Condition ☐
- Tuberculosis ☐
- Ulcers ☐
- Varicose Veins ☐
- Venereal Disease ☐
- Other: ☐

Current Complaints (Continued)

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache
B=Burning
N=Numbness
O=Other
P=Pins & Needles
S=Stabbing



Heartwood Holistic Health

Patient Informed Consent

Congratulations on choosing chiropractic health care. This clinic believes it is the safest, most natural, and most cost effective health care delivery system in the world today. Chiropractic is the science that concerns itself with the relationship between the brain, central nervous system, spine, and the function of the body. Any alteration of this relationship can cause the biomechanical and neurophysiological dynamics of the contiguous spinal and paraspinal structures to be disrupted. This can cause neuronal disturbances in the form of the vertebral subluxation complex (V.S.C.) with its physical and chemical components, which can then interrupt the body's inherent recuperative powers.

The practice of chiropractic can include exams and diagnostic testing. This often includes the utilization of specialized instrumentation, lab tests, radiological exams, nutritional and/or physical therapy, and rehabilitation procedures, etc. The chiropractic adjustment (chiropractic manipulative therapy- C.M.T.) is made by chiropractor to correct and/or reduce and/or stabilize vertebral or extremity subluxation complexes. The goal of chiropractic health care is to reduce and/or stabilize the nerve interference caused by the VSC and its component parts. There are over 200 different adjusting techniques, some using specialized equipment. Adjustments are usually performed by hand, but may be performed by hand-guided instruments. A C.M.T is the application of a specific force, applied to a segmental contact point, usually on a vertebra, to reduce or stabilize the V.S.C. and its component parts.

All health care professionals (anesthesiologists, chiropractors, dentists, medical doctors, osteopaths, pharmacists, surgeons, etc.) are regulated by laws and boards. These health care professionals are required to give you, the patient, advance notice of any care risks, because health care is not an exact science. It is not reasonable to expect any doctor to foresee all risks and/or complications. Your care may involve the making of recommendations based upon facts known to the doctor at this time. Chiropractic care does not use drugs or surgery, and does not diagnose internal and/or medical conditions. For your information, the following is furnished to all patients who request and/or accept chiropractic care in this clinic. This clinic is staffed with graduate chiropractors, who are licensed and recognized by government agencies regulating all the aforementioned healing arts.

You should understand the benefits of chiropractic health care, but you also need to be aware of some of the limited inherent risks. These occur seldom enough to contraindicate care, but should be considered in your informed decision to receive chiropractic care. All health care procedures have some risks. With C.M.T.'s these risks may include musculoskeletal sprain/strain, disc injuries, dislocations, fractures, neurological deficits, Horner's Syndrome, Vertebral Artery Syndrome (V.A.S.), stroke, etc. The chances of this occurring have been estimated by experts to be approximately only one per 400,000 treatments to one per 1,000,000 treatments. Appropriate tests will be performed to identify if you may be susceptible to these risks, and you will be notified in that case. If you have any questions about these issues, please do not hesitate to speak with your doctor of chiropractic.

I have read (or have had read to me) the above information. I wish to rely on the doctor's judgment during my course of care, based on the facts then known. I have also had the opportunity to ask questions regarding the above information and possible consequences and risks. By signing below, I now agree to have the chiropractic care procedures recommended and performed. I have no questions, and I acknowledge no guarantee of cure or results has been made to me concerning results, care and treatment.

_____ _____

Patient Name Printed *Patient Signature* *Date*

Heartwood Holistic Health

THIS OFFICE IS HIPAA COMPLIANT

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI) FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

As part of your healthcare, this practice originates and maintains health records describing your health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning care and treatment
- A means of communication among the many health professionals that contribute to your care
- A source of information for applying your diagnosis and treatment information to your bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing the quality and reviewing the competence of healthcare professionals

I understand that the **HIPAA Chiropractic Notice of Privacy Practice** is available to me upon request and online at http://heartwoodholistic.com/notice-of-privacy-practice.html The Notice provides a more complete description of information uses and disclosures. I understand that I have the right to review this Notice prior to signing this consent. I understand that the organization reserves the right to change its Notice and practices. I understand that I have the right to object to the use of my health information for directory purposes.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance therein.

I wish to have the following restrictions to the use or disclosure of my health information (if applicable):

I fully understand and accept the terms of this consent.

_____ _____

Patient Signature *Date*

_____ _____

Staff Signature *Date*

Heartwood Holistic Health

Patient Election to Self-Pay for Services

Heartwood Holistic Health, PLLC has opted to be an out of network provider and DOES NOT file health insurance claims on behalf of its patients with in-network or out-of-network primary or secondary health insurance carriers. Heartwood Holistic Health, PLLC will furnish a visit statement (super bill) for services rendered to be filed by the patient. The Health Insurance Portability and Accountability Act (HIPAA) also allows me to choose to not file health insurance claims.

I understand and agree that I will pay Heartwood Holistic Health, PLLC directly for all services rendered with cash, check, or acceptable credit card.

_____ _____

Patient Name Printed *Patient Signature* *Date*

Cancellation Policy

We respectfully ask that you give us at least 24 hours notice if you need to reschedule or cancel your appointment. Please call us at (919) 929-5610 to change your appointment.

More than 24 hours notice	Service will be canceled/rescheduled at no charge
Less than 24 hours notice	50% of the service price will be charged
Failure to show without notice	100% of the service price will be charged