HAMPSTEAD CHIROPRACTIC

Phone: (910) 803-0797
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Hampstead, NC 28443
Hampsteadchiropracticnc.com

Hampstead Chiropractic New Patient Intake Form

Profile Information

First Name_____ Last Name _____

Preferred Name (if different)_____

Date of Birth _____/_____/_____

Mobile Phone (_____)-_____-_____

Address _____

_____

_____

Sex M F (please be sure this matches what your insurance provider has on file if we are billing)

Emergency Contact Name _____

Emergency Contact Phone (_____)-_____-_____

Emergency Contact Relationship _____

Family Doctor _____

Family Doctor Phone (if known) (_____)-_____-_____

How did you hear about us? _____

Health Questionnaire

Chief Complaint _____

Other Concerns _____

Have you previously been under chiropractic care? If Yes, where?

- ☐ Yes _____
- ☐ No

Details of Chief Complaint:

When did you begin to experience this? _____

Have you experienced this previously? _____

Progression of Pain (please circle) Worsening Staying the Same Improving

Frequency (please circle) Occasional/Intermittent Constant With Movement
Worse in the Morning Worse in the Evening/Night

Intensity (please circle) 0 1 2 3 4 5 6 7 8 9 10

Character (please circle) Dull Achy Sharp Stabbing Burning Shooting Tingling
Radicular Symptoms Other Description_____

What Aggravates the Chief Complaint? _____

What Relieves the Chief Complaint? _____

What is your sleeping position? (please circle) Back Side Stomach

Other associated symptoms _____

Medical History Questionnaire

Please Circle if applicable to you. Diabetes Hypertension Heart Attack Stroke Cancer Other _____

Please Circle if in Family History. Diabetes Hypertension Heart Attack Stroke Cancer Other _____

Details: _____

Lifestyle

- ☐ Exercise-how often?_____
- ☐ Balanced Diet
- ☐ Poor Diet
- ☐ Supplements/Vitamins-please list_____
- ☐ Drink Alcohol-how often_____
- ☐ Smoke-how often_____
- ☐ Sleep (please circle) less than 4 hours 5-6 hours 7-8 hours
- ☐ Poor Sleep
- ☐ Allergies-please list _____
- ☐ Medications-please list _____

Other lifestyle details you'd like to note: _____

Is your condition interfering with the following? If so, please explain how

- ☐ Work _____
- ☐ Sleep_____
- ☐ Daily Routines _____
- ☐ Other _____

What is your occupation? _____

How stressful is your job? (please circle) Not Stressful Mildly Stressful Very Stressful

Past Traumas or Surgeries

_____

_____

_____

Are you Currently Pregnant? (please circle) Yes No Not Applicable

Have you been in a Motor Vehicle Accident? If Yes, please briefly describe any injuries.

- ☐ Yes _____
- ☐ No

Do you have any of the Following?

- ☐ Night Pain
- ☐ Unexpected Weight Loss
- ☐ Fever
- ☐ Low Blood Pressure
- ☐ Sudden Numbness or Weakness of Face

Symptom Review

- ☐ Dizziness
- ☐ Double Vision
- ☐ Headaches
- ☐ Ringing in Ears
- ☐ Trouble Swallowing/Speaking
- ☐ Chest Pain/Palpitations
- ☐ Difficulty Breathing
- ☐ Digestive Issues
- ☐ Bowel or Bladder Changes
- ☐ Skin Rashes
- ☐ NO ISSUES

Please List Other Doctors Consulted for these Conditions

_____

Expectations and Goals of Treatment:

_____

_____

_____

Consent Forms

Consent for Physical Exam

- ☐ Yes
- ☐ No

PLEASE READ THE FOLLOWING STATEMENT ENTIRELY AND SIGN BELOW

I hereby authorize Dr. Haberl or his assistants to examine me, including X-rays if indicated by the exam, and to release my records to anyone I designate. I further authorize treatments deemed necessary by the findings and I wish all my chiropractic records to be held in strict secret confidence and not to be given to anyone without my written consent. I authorize direct payment to the doctor from my insurance company and I clearly understand that I am totally responsible for payment should my insurance company deny payment or make payment to me. BY SIGNING YOUR NAME BELOW YOU CERTIFY THE ACCURACY OF YOUR MEDICAL AND/OR ACCIDENT HISTORY AND FURTHER CERTIFY THAT YOU PRESENT TO DR. HABERL FOR EVALUATION AND/OR TREATMENT OF A HEALTH RELATED CONDITION AND FOR NO OTHER PURPOSE.

Name of Person Responsible for Payment _____

Signature _____ Date _____/_____/_____

Signature of Guardian_____ Date _____/_____/_____

Communications

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments. Please check the following you would like to receive.

- ☐ I would like email notifications of new, canceled, and rescheduled appointments
- ☐ Email 2 days before appointment
- ☐ Text Message (SMS) 1 hour before appointment

Please read each of the following and Initial stating you agree and understand

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

_____ I agree

Accuracy of Information

_____ I certify that the above medical information is correct to the best of my knowledge

Payment Policy and Informed Consent

Our primary goal is to provide quality chiropractic care to all of our patients. It is necessary to establish payment policies to avoid any misunderstandings. Therefore, we wish to clarify the following policies by our practice.

All co-pays and unpaid deductibles are due and expected at the time the services are rendered. Even though you may have an insurance claim pending, you will receive a statement each month for the outstanding balance of your account. We cannot accept responsibility for collecting an insurance claim or for negotiating a disputed claim. Insurance reimbursement is a contract between you and your carrier. You are responsible for your bills regardless of what your insurance pays. Bills which remain unpaid for over 60 days will be charged a 1.5% interest per month.

I have read this payment policy and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account within the usual limits of this policy.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, electrical muscle stimulation, radial pulse wave therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Conner Haberl and/or other licensed doctors or chiropractors who now or in the future work at the office listed above or any other office.

I have had an opportunity to discuss with Dr. Conner Haberl and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her is in my best interest.

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

_____ I agree

HIPAA Patient Authorization Form

Hampstead Chiropractic is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. You have the right to review our Notice before signing this Authorization and you are advised to do so. This authorization for release of information covers the period of healthcare from today's date to exactly one year from today.

By signing this form, you authorize our use and disclosure to third parties, including but not limited to doctors, nurses, technicians, medical students, or other facility personnel who are involved in taking care of you in this facility. If you sign this Authorization but later change your mind, you have the right to revoke this Authorization by delivering to us a written, dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on our prior authorization.

The patient understands and agrees that:

· The Clinic has a Notice of Privacy Practices. The patient has received and had the opportunity to review this Notice before signing the Authorization. The Clinic encourages all patients to review the Notice of Privacy Practices.

· The Clinic reserves the right to modify the Notice of Privacy Practices to keep up with change in the law or office practices. We will make all modifications available for review by patients.

· All my medical records and protected health information may be disclosed or used for treatment, payment, or health care operations. The Clinic will not receive any payment from a third party in connection with the use or disclosure of your PHI.

· The Clinic or its business affiliates may use your PHI to contact you with appointment reminders and educational and promotional items in the future via email, U.S. Mail, telephone, fax and/or prerecorded messages. We WILL NOT ever sell or ‘SPAM’ your personal contact information.

· The patient has the right to restrict the uses of his or her information, but the Clinic does not have to agree to all such restrictions.

· The patients may revoke this Authorization in writing at any time and all future disclosures that require the patient’s prior written authorization will then cease. See the Notice of Privacy Practices for additional details.

· The Clinic may not condition your treatment or payment on whether you sign this Authorization.

Information used or disclosed pursuant to this Authorization may be re-disclosed by the recipients and may no longer be protected by federal or state law.

Please list anyone with whom you would like to allow access to your personal information. IF THEY ARE NOT LISTED HERE, WE CANNOT SHARE ANY INFORMATION WITH THEM, OR ALLOW THEM TO SCHEDULE YOUR APPOINTMENTS. If there is no one you would like to allow this access, please put "SELF".

Name of Authorized Person(s)	Relationship to you (If no one, please put self)

Please sign below stating you have read and understand the HIPAA Form

_____ _____

Signature of patient or Guardian Authorized Date