BYER CLINIC OF CHIROPRACTIC

"Tender Care to Improve Spinal Function"

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PATIENT INTAKE FORM

Name:_____ **SS#:**_____ **DOB:**_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Home #:_____ **Cell #:**_____ **Email:**_____

Single ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced** ☐

Patient employed by:_____ **Work #:**_____

Business Address:_____

Notify in case of emergency:_____ **Phone #**_____

Person responsible for Insurance account _____

Insured DOB:_____ **Insured SS#:**_____

Whom may we thank for referring you to our office?:_____

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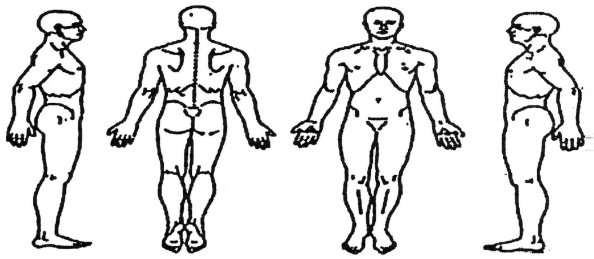
1. Is today's problem caused by: ☐ Auto Accident ☐ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



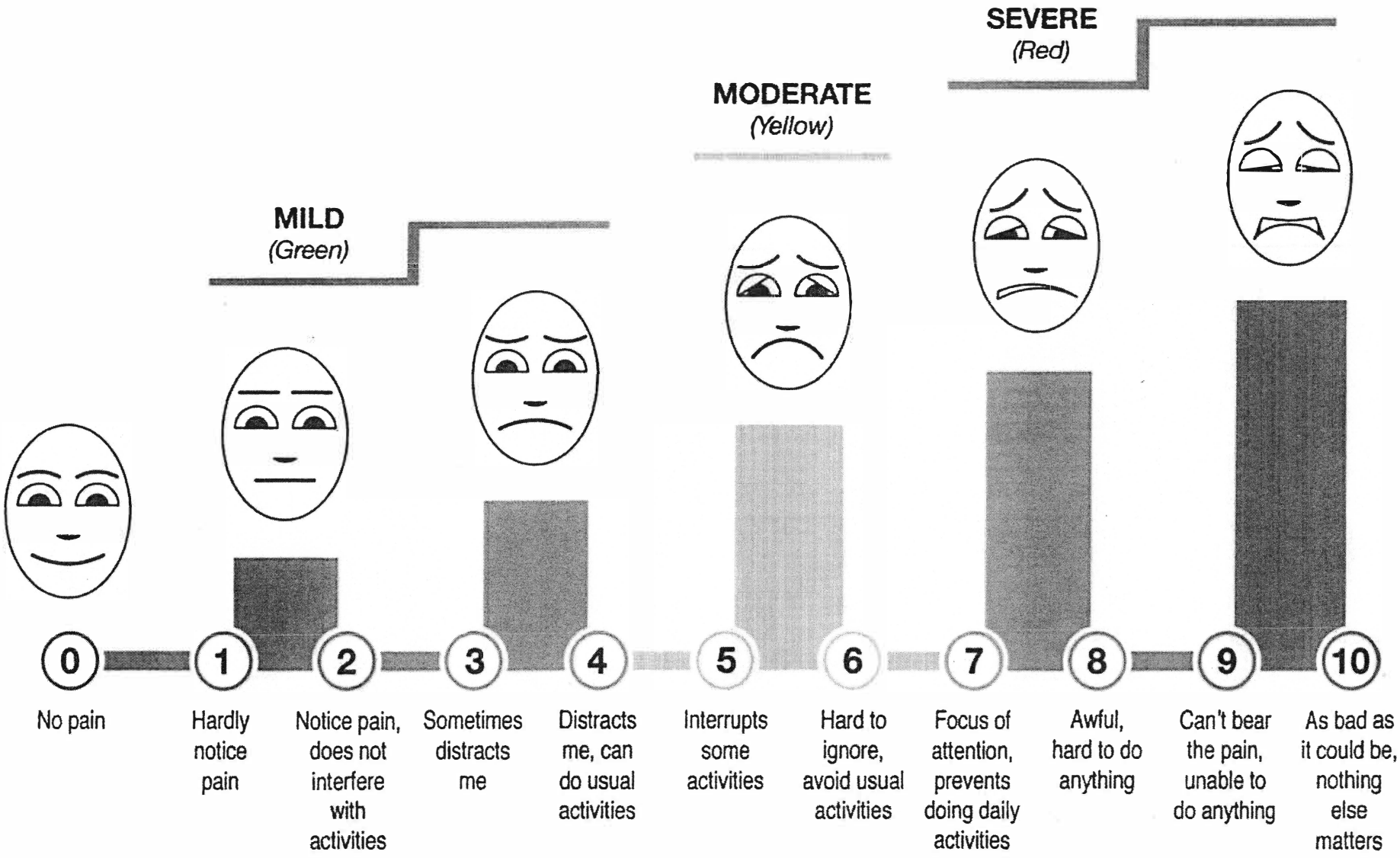
3. How often do you experience your symptoms?

☐ Constantly (76-100% of the time)
☐ Frequently (51-75% of the time)
☐ Occasionally (26-50% of the time)
☐ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

☐ Sharp
☐ Dull
☐ Diffuse
☐ Achy
☐ Burning
☐ Shooting
☐ Numb
☐ Tingly
☐ Sharp with motion
☐ Shooting with motion
☐ Stabbing with motion
☐ Electric like with motion

Defense and Veterans Pain Rating Scale



v 2.0

☐Stiff ☐Other:_____

5. How are your symptoms changing with time?
☐Getting Worse ☐Staying the Same ☐Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10

7. How much has the problem interfered with your work?
☐Not at all ☐A little bit ☐Moderately ☐Quite a bit ☐Extremely

8. How much has the problem interfered with your social activities?
☐Not at all ☐A little bit ☐Moderately ☐Quite a bit ☐Extremely

9. Who else have you seen for your problem?
☐Chiropractor ☐Neurologist ☐Primary Care Physician
☐ER physician ☐Orthopedist ☐Other:_____
☐Massage Therapist ☐Physical Therapist ☐No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?
☐Yes ☐Yes, at times ☐No

13. What aggravates your problem?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ **Weight** _____ **Age** _____
Occupation _____

16. How would you rate your overall Health?
☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

17. What type of exercise do you do?
☐Stenuous ☐Moderate ☐Light ☐None

18. Indicate if you have any immediate family members with any of the following:
☐Rheumatoid Arthritis ☐Diabetes ☐Lupus
☐Heart Problems ☐Cancer ☐ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
☐	☐Headaches	☐	☐High Blood Pressure	☐	☐Diabetes
☐	☐Neck Pain	☐	☐Heart Attack	☐	☐Excessive Thirst
☐	☐Upper Back Pain	☐	☐Chest Pains	☐	☐Frequent Urination
☐	☐Mid Back Pain	☐	☐Stroke	☐	☐Smoking/Tobacco Use
☐	☐Low Back Pain	☐	☐Angina	☐	☐Drug/Alcohol Dependance
☐	☐Shoulder Pain	☐	☐Kidney Stones	☐	☐Allergies
☐	☐Elbow/Upper Arm Pain	☐	☐Kidney Disorders	☐	☐Depression
☐	☐Wrist Pain	☐	☐Bladder Infection	☐	☐Systemic Lupus
☐	☐Hand Pain	☐	☐Painful Urination	☐	☐Epilepsy
☐	☐Hip Pain	☐	☐Loss of Bladder Control	☐	☐Dermatitis/Eczema/Rash
☐	☐Upper Leg Pain	☐	☐Prostate Problems	☐	☐HIV/AIDS
☐	☐Knee Pain	☐	☐Abnormal Weight Gain/Loss		
☐	☐Ankle/Foot Pain	☐	☐Loss of Appetite	**For Females Only**	
☐	☐Jaw Pain	☐	☐Abdominal Pain	☐	☐Birth Control Pills
☐	☐Joint Pain/Stiffness	☐	☐Ulcer	☐	☐Hormonal Replacement
☐	☐Arthritis	☐	☐Hepatitis	☐	☐Pregnancy
☐	☐Rheumatoid Arthritis	☐	☐Liver/Gall Bladder Disorder		
☐	☐Cancer	☐	☐General Fatigue		
☐	☐Tumor	☐	☐Muscular Incoordination		

☐ ☐Asthma ☐ ☐Visual Disturbances
☐ ☐Chronic Sinusitis ☐ ☐Dizziness
☐ ☐Other:_____

20. List all prescription medications you are currently taking:

21. List all of the over-the-counter medications you are currently taking:

22. List all surgical procedures you have had:

23. What activities do you do at work?

☐ **Sit:**	☐ Most of the day	☐Half the day	☐A little of the day
☐ **Stand:**	☐ Most of the day	☐Half the day	☐A little of the day
☐ **Computer work:**	☐ Most of the day	☐Half the day	☐A little of the day
☐ **On the phone:**	☐ Most of the day	☐Half of the day	☐A little of the day

24. What activities do you do outside of work?

_____

25. Have you ever been hospitalized? ☐No ☐Yes
if yes, why _____

26. Have you had significant past trauma? ☐No ☐Yes

27. Anything else pertinent to your visit today?_____

AUTHORIZATION

I understand that I am responsible for payment of all deductibles and co-payments related to my care. I understand if my balance is not paid per my financial agreement, I promise to pay any and all collection, court, and attorney fees in the collection of my account. I further understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of the fee schedule regardless of the outcome of my case. I understand that if a check is returned for insufficient funds, I will be charged a $25.00 service charge.

I have read and fully understand the above financial terms.

Signed_____ Date_____

Policy for Patients

To help you receive the greatest benefit from your care, all patients are accepted for care based on the following policies:

X-Rays- In an effort to provide you with the highest quality health care, a board-certified radiologist from Specialized Radiology Consultants (SRC) reads x-rays taken at the clinic. This is a separate charge from any clinic charges for examination and taking of the x-rays. If you have insurance, it will be billed by SRC, and any balances are your responsibility.

Financial Agreements- It is your payment that allows us to continue providing high levels of professional care, maintain our facility and pay our staff. If for any reason you cannot keep your financial agreement, inform us **immediately** to eliminate any misunderstandings. We will make every attempt to make affordable arrangements.

Massage Therapy- This is a 30-minute adjunctive procedure that may be recommended by the doctor and implemented by a certified massage therapist on staff. The therapy is scheduled so if you are running late you will receive the remaining portion of your time. In the event you break your appointment and fail to notify the clinic **1 HOUR** prior to your appointment time, a **$40 fee** is charged for the therapist time.

Interruption of Care- In the event that it is necessary to discontinue your care for any reason, any outstanding fees for services including co-payments and deductibles already rendered become immediately due and payable.

REMEMBER that healing and spinal correction takes time. If at any time during your care you do not feel that you are not responding as well as you expected, please schedule a consultation with the doctor. **We want you to get the most from your chiropractic care.**

Our practice is built upon **"word of mouth"** referrals from our satisfied patients. **We thank you for sharing us with others.**

I have read and understand the above policies and agree to abide by them.

_____ _____

Today's Date Patient's Signature

Byer Clinic of Chiropractic, LTD • (847) 637-3933

Protecting Your Confidential Health Information is Important to Us

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Promise!

Dear Patient:

This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA - Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

So what has changed? Why a privacy policy now? Very good questions!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

How your HEALTH INFORMATION may be used

To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between physician assistant, nurse, physician and business office staff. In addition we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and curative care modern medicine can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

To Coroners, Funeral Directors and Medical Examiners

We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral.

Medical Research

Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval of an Institutional Review Board.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Acknowledgment

Patient Name(s):_____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

_____

Patient Signature

Date _____ /_____ /_____

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

#FM-0306 • Printed in U.S.A.

Pre- Authoritative Healthcare Form

I authorize Byer Clinic of Chiropractic to keep my signature on file and to charge any Mastercard or Visa as indicated below:*

Check one: ☐ MasterCard ☐ Visa ☐ Other _____

Will be charged if balance of charges not paid by insurance within 30 days

Card Information:

Cardholder name: _____

Cardholder Billing Address: _____

City: _____ State: _____ Zip: _____

Account Number: _____

Exp. _____ CVV. _____

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel authorization through written notice to the Healthcare provider.

X_____ _____

Cardholder Signature Date