

GRAHAM CHIROPRACTIC CENTER, INC.

Bryan Graham, DC, CCSP

110 Long Pond Road, Suite 210 ~ Plymouth, MA 02360 ~ (508)747-1434

New Patient Intake Form

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please fill out this form as completely as possible. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help. (Please Print Below)

Name \_\_\_\_\_ Today's Date \_\_\_\_\_
First Middle Initial Last

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex: \_\_\_Female \_\_\_Male Birth date \_\_\_/\_\_\_/\_\_\_ E-Mail \_\_\_\_\_

Cell Phone (\_\_\_) \_\_\_\_\_ Home Phone (\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_) \_\_\_\_\_

Do you prefer to receive calls at? \_\_\_Cell \_\_\_Home \_\_\_Work

Are you: \_\_\_Married \_\_\_Widowed \_\_\_Single \_\_\_Minor \_\_\_Separated \_\_\_Divorced

Patient Employer/School \_\_\_\_\_

Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone (\_\_\_) \_\_\_\_\_

Whom may we thank for referring you to our office: \_\_\_\_\_

- Race: \_\_\_ American Indian or Alaska Native
\_\_\_ Asian
\_\_\_ Black or African American
\_\_\_ White
\_\_\_ I choose not to answer/identify

- Ethnicity: \_\_\_ Hispanic or Latino
\_\_\_ Not Hispanic or Latino
\_\_\_ I choose not to answer/identify

Responsible Party

Name of person responsible for this account \_\_\_\_\_ Phone (\_\_\_) \_\_\_\_\_

Insurance Information

Name of insured \_\_\_\_\_ Relationship patient \_\_\_\_\_

How many Chiropractic visits have you used in your service year so far? \_\_\_\_\_

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever had a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to Dr. Graham all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Graham may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Reasonable \_\_\_\_\_ Date \_\_\_\_\_

# GRAHAM CHIROPRACTIC CENTER, INC.

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

## Health History

Check only those conditions which are applicable:

- |  |  |   |  |   |
|--|--|---|--|---|
| <input type="checkbox"/> Alcoholism        | <input type="checkbox"/> Cataracts     | <input type="checkbox"/> Hernia             | <input type="checkbox"/> Pacemaker         | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> AIDS/HIV          | <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Herniated Disc     | <input type="checkbox"/> Parkinson's       | <input type="checkbox"/> Tonsillitis      |
| <input type="checkbox"/> Allergy Shots     | <input type="checkbox"/> Depression    | <input type="checkbox"/> Pinched Nerve      | <input type="checkbox"/> Pneumonia         | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Polio             | <input type="checkbox"/> Tumors/Growths   |
| <input type="checkbox"/> Anorexia          | <input type="checkbox"/> Emphysema     | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Appendicitis      | <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Prosthesis        | <input type="checkbox"/> Whooping Cough   |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Fractures     | <input type="checkbox"/> Measles            | <input type="checkbox"/> Psychiatric Care  | <input type="checkbox"/> Other _____      |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Glaucoma      | <input type="checkbox"/> Migraines          | <input type="checkbox"/> Rheumatic Fever   | _____                                     |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Goiter        | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Scarlet Fever     | _____                                     |
| <input type="checkbox"/> Breast Lump       | <input type="checkbox"/> Gout          | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Stroke            |   |
| <input type="checkbox"/> Bronchitis        | <input type="checkbox"/> Gonorrhea     | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Substance Abuse   |   |
| <input type="checkbox"/> Bulimia           | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Suicide Attempt   |   |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Hepatitis     | <input type="checkbox"/> Osteoporosis       |  |   |

(Women) Are you pregnant? Yes No      Nursing? Yes No

List any types of surgeries which you have had and the Dates which they occurred:

\_\_\_\_\_

Do you have any replacement joints or other hardware?

\_\_\_\_\_

Allergies: \_\_\_\_\_

## Daily Habits

What type of exercise do you perform on a daily basis? None    Moderate    Heavy

What do your daily work habits include? (Ex: sitting, standing, light labor, heavy labor, computer work)

\_\_\_\_\_

Do you smoke? Yes No    How much per day? \_\_\_\_\_

How much coffee or caffeinated beverages do you consume on a daily basis? \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

Please list all current medications, Vitamins and supplements:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

**Symptoms**

Reason for visit \_\_\_\_\_

When did you first notice the symptoms? \_\_\_\_\_

Is this condition getting progressively worse? \_\_\_\_\_

Which activities are difficult to perform?  Sitting  Standing  Walking  Bending  Lying Down

Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  Burning

Tingling  Cramps  Stiffness  Swelling  Other

Rate the severity of your pain (1 is mild to 10 being severe) 1 2 3 4 5 6 7 8 9 10

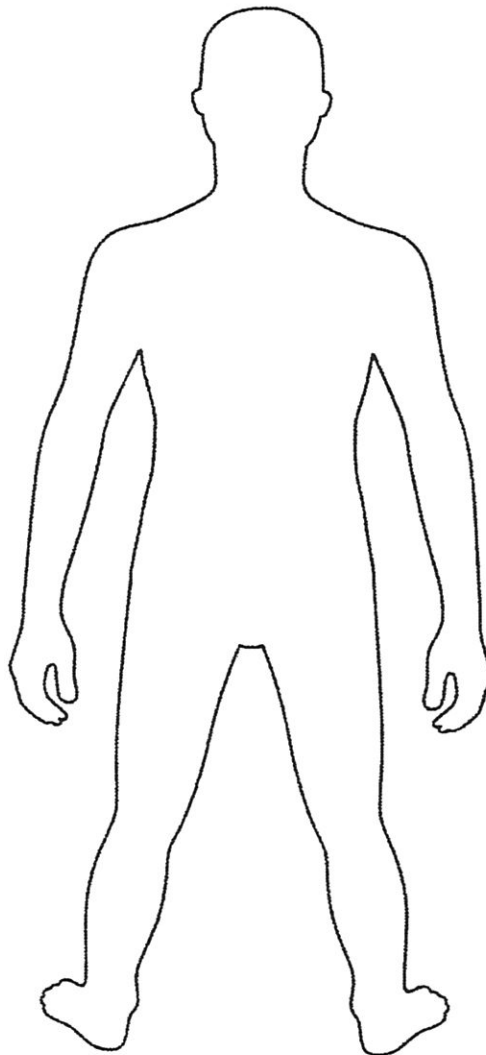
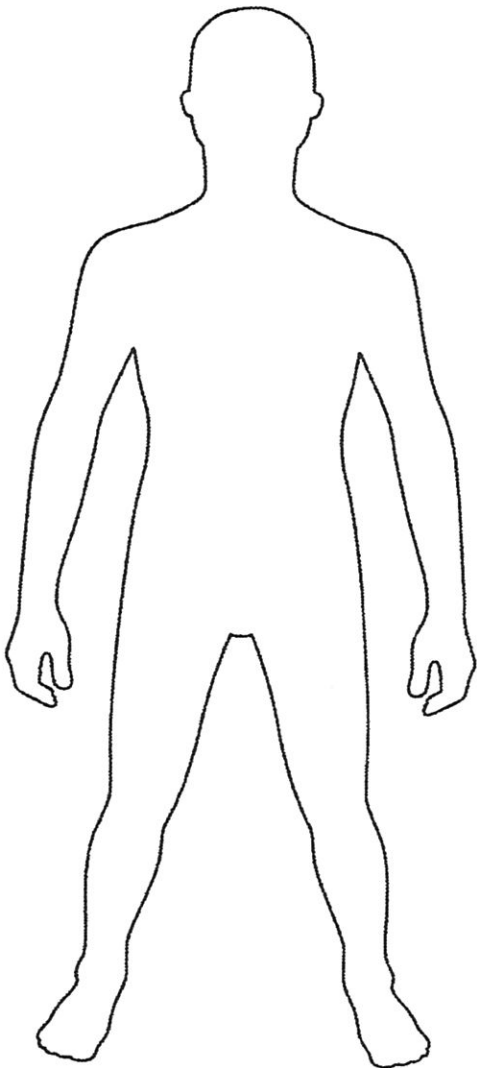
Is the pain constant or does it come and go? \_\_\_\_\_

What treatment have you already received for your condition?

Medication  Surgery  Physical Therapy  Other \_\_\_\_\_

Name of the other doctor(s) who have treated you for your condition: \_\_\_\_\_

Where specifically is the problem(s) located?



# Financial Agreement

Please read all areas as your status may change throughout your care plan.

## Patients with Group or Individual Insurance

When possible, we will call to verify benefits on your Insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Payment will be due by you at the time of service for any co-payments or deductibles. Any services not covered by your insurance or remaining balances are your responsibility and will be billed to you after payment by your insurance is received. Co-payments are due at the time of service.

## Patients with Medicare

We do accept assignment from Medicare. The payment is usually sent directly to our office in payment of the services that Medicare will cover which for chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the remaining 20% as well as any non-covered services. Our office completes and file the forms for Medicare at no charge.

I have read and understand the Medicare information page \_\_\_\_\_

## Secondary Insurance

Please inform us of any secondary insurance you may have. For patients with Medicare your secondary insurance may pay for remaining fees.

## “On the Job” Injury (Worker’s Compensation)

If you are injured on the job, your care should be paid for under your employer’s Worker’s Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 8 months, or if you suspend or terminate care, any fees and services are due immediately.

## Personal Injury or Automobile Accidents

Please notify your auto insurance carrier of your visit to our office immediately. Notify us if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim up to 6 months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

## Cash Paying Patients

If you do not have insurance or if your insurance does not cover chiropractic care we provide payment options. Payment at the time of service is preferred. Any outstanding balances will be billed to you. We accept cash, personal checks and debit/credit cards.

*I have read and understand the payment policy of Graham Chiropractic Center. I understand that my insurance is a arrangement between myself and my insurance company, not between Graham Chiropractic Center and my insurance company. I understand that if my insurance does not respond within 60 days or if I suspend or terminate my scheduled care as prescribed by the doctors at Graham Chiropractic Center that fees will be due and payable immediately.*

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Patient’s Signature (or guardian if a minor)

Date

## **MISSED APPOINTMENT POLICY**

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients the best optimal spinal care, we request that the follow our guidelines regarding broken and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice. You have the option of leaving a message on our machine any time, 24 hours a day as well as cancelling via your text message reminder.

You will be charged for ALL appointments that are not cancelled within 24 hrs, including SAME DAY cancellations. Fees must be paid prior to your next visit with us.

We booked your appointments in order to provide you with eh best schedule possible for your busy life. If there is a plan of care change, please make sure to update your scheduled visits in order to avoid a no show fee.

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Patient Signature

Date

# NON- COVERED SERVICE WAIVER

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Provider Name: \_\_\_\_\_

I \_\_\_\_\_, understand that the services and/or supplies rendered to me may not be eligible for benefits (e.g. service may be determined to not be medically necessary, non-covered or investigated) by \_\_\_\_\_.

I understand that my health insurance has certain restrictions and limitations such as non-covered services and/or limited visits per year. Since I have chosen to receive the services, I agree to be financially responsible for any and all related charges that are not covered by my insurance.

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Patients Signature

Date

I, Bryan Graham, certify that I have informed my patient that \_\_\_\_\_ may not cover certain services under the members plan as they are considered non-covered services or there may be a limited number of visits per year.

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Providers Signature

Date

## Informed Consent to Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnosis X-Rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic name below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the 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, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and 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 an opportunity to ask questions about its content, 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.

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Patients Name

Signature

Date

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

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Patient Signature

Date

“Chiropractic care for a balanced life”