Weber Chiropractic Clinic
101 W Hwy 78, Unit 2
Richland, IA 52585

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: _____ **Last Name: _____**

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language: _____**

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer
Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____Date: _____

For office use only

Height: _____ **Weight: _____** **Blood Pressure: ____/_____**

WEBER CHIROPRACTIC
Patient Intake Form

Title: (Circle one) Mr. Mrs. Ms. Miss Dr. Other _____ **Todays Date**: _____

First Name _____ Middle Initial ____ Nick Name _____

Last Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____

Cell Phone (_____) _____-_____

Date of Birth _____/_____/_____ **Age : ____** **Sex:** □ Male □ Female

Social Security Number: _____-_____-_____ Marital Status: □ Single □ Married □ Other

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Employment Status: □ Employed □ Unemployed □ FT Student □ PT Student □ Other_____

Employer _____

Your Occupation _____

Spouse Data_____

First Name _____ Middle Initial ____ Last Name _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____

Spouse Date of Birth _____/_____/_____ Employment: _____

Emergency Contact (if different than above)_____

Contact Name _____ Relationship to Patient _____

Contact Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

How did you hear about our office? _____

Medical Conditions: (Circle all that apply to you)

Arthritis	Asthma	Cancer	Cholesterol	Diabetes
Fibromyalgia	Heart Disease	Hypertension	Kidney disease	Liver disease
Osteoporosis	Prostate	Psychiatric Illness	Skin Disorder	Stroke
Thyroid Problems	Other _____			

Surgeries: (Circle all that apply to you)

Appendectomy	Brain	Breast Augmentation	Cardiovascular Procedure
Carpal Tunnel	Cervical Spine	Colonoscopy	Endoscopy
Gall Bladder	Gastrointestinal	Hernia	Hysterectomy
Joint Replacement	Knee	Lumbar Spine	Prostate
Shoulder	Thoracic Spine	Uro-genital	Other _____

Allergies: (Circle all that apply to you)

Animal	Chemical_____	Milk/Lactose	Mold
Seasonal	Sulfites	Wheat/Gluten	Other_____

Social History: (Circle all that apply to you)

Drink Alcohol:	Never	Social	Light	Moderate	Heavy
Cigarettes:	Never	Social	Light	Moderate	Heavy
Caffeine Use:	Never	1 cup/day	2-4 cups/day	5+ cups/day	
Exercise:	Never	1 time/week	Few times/week		Daily
Water Intake:	None	<64 oz/day	>64 oz/day		
Sleep:	<8 hours/night		>=8 hours/night		Insomnia

Family History: (Circle all that apply)

Arthritis	Mother	Father	Brother	Sister	Son	Daughter	
Cancer	Mother	Father	Brother	Sister	Son	Daughter	Type _____
Diabetes							
Type 1	Mother	Father	Brother	Sister	Son	Daughter	
Type 2	Mother	Father	Brother	Sister	Son	Daughter	
Heart Disease	Mother	Father	Brother	Sister	Son	Daughter	Condition _____
Hypertension	Mother	Father	Brother	Sister	Son	Daughter	
Stroke	Mother	Father	Brother	Sister	Son	Daughter	
Hypothyroid	Mother	Father	Brother	Sister	Son	Daughter	
Hyperthyroid	Mother	Father	Brother	Sister	Son	Daughter	
Epilepsy	Mother	Father	Brother	Sister	Son	Daughter	
MS	Mother	Father	Brother	Sister	Son	Daughter	
Parkinson's	Mother	Father	Brother	Sister	Son	Daughter	
Alzheimer's	Mother	Father	Brother	Sister	Son	Daughter	

Do you have a history of headaches/migraines?

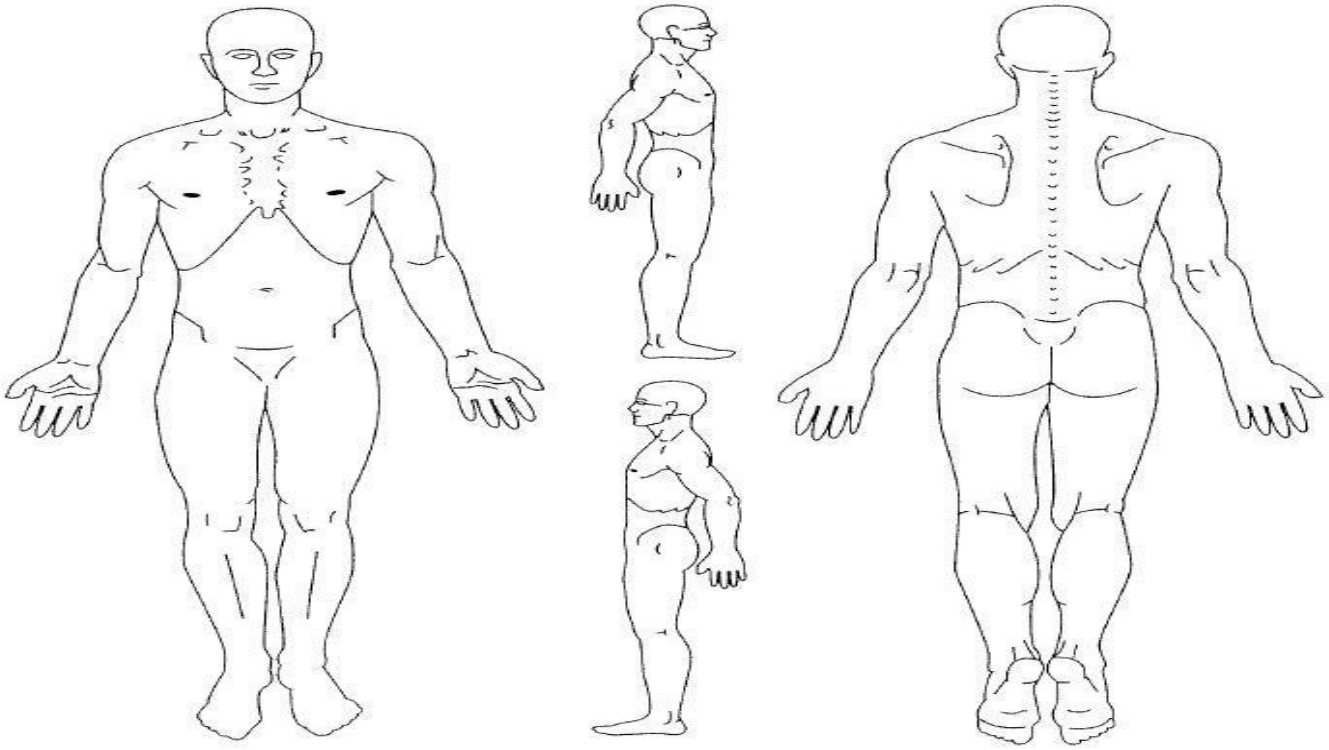
Right now? Yes / No
How frequent? Daily Weekly Monthly
Describe the pain/aura. _____
What area do you experience the headache?
_____
Does anything make them better? Yes / No
If so, what? _____

In the past year, have you…

Had an **x-ray** of your low back? Yes / No
Had a **CT** of your low back? Yes / No
Had a **MRI** of your low back? Yes / No

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Sharp T=Tingling A=Dull Ache



Average Pain Intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Does anything improve your pain? Yes No **If Yes, please list:**

When did your symptoms begin? _____

Are your symptoms a result of: □ Motor Vehicle Accident □Work related Accident □ Other_____

How did your symptoms begin? _____

_____

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day) □ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

□ Sharp □ Ache □ Numb □ Shooting

□ Burning □ Tingling □ Throbbing □ Other _____

OFFICE POLICY

Thank you for choosing Weber Chiropractic as your Chiropractic provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, we have developed this payment/office policy. Please read it, ask any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

1. **INSURANCE. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility, contact your insurance company with questions you may have regarding coverage. If your insurance company requires a referral it is your responsibility to provide us with a referral dated the day of your first visit from your primary care physician prior to your first visit. We are only able to provide a summary of your chiropractic benefits.**
2. **CO-PAYMENT AND DEDUCTIBLES**. **All co-payments and deductibles must be paid at the time of service.** This arrangement is part of your contract with your insurance company. Failure to collect co-payments and deductibles from patients can be considered fraud. Please help us uphold the law by paying your co-payment at each visit.
3. **PROOF OF INSURANCE**. Patients must complete all patient information forms before seeing the provider. Please provide us with the most up to date insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
4. **CLAIM SUBMISSION**. We will submit your claims and assist you in any way we reasonably can to help get your claim paid. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.
5. **COVERAGE CHANGES**. If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.
6. **RETURNED CHECKS.** We will charge a $20 service fee for returned checks.

Please help us to serve you better by keeping your regular scheduled appointment.
Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. **As of Dec. 1 2014, we will be charging a $25 fee for missed appointments and any cancellations less than 24 hours in advance. $100 fee for New Patient missed appointments.**

I have read and understood the payment policy and agree to abide by its guidelines.

_____ _____
Signature of patient or responsible party **Date**

WEBER CHIROPRACTIC, PLC
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)
AUTHORIZATION & ASSIGNMENT

THE PERSON IDENTIFIED AUTHORIZES WEBER CHIROPRACTIC TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

- **I give permission to Weber Chiropractic to use my name, address, email, and phone number to contact me with appointments, reminders, missed appointments, greeting cards, as well as information about chiropractic care.**
- **If Weber Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.**
- **I give Weber Chiropractic permission to adjust me within the adjusting room. I am aware that other persons in the office may overhear some of my health information and casual conversation during the course of care. The staff will do their best to keep my information and conversation private.**
- **If you have insurance benefits and elect to use these benefits, we will use your information to process your insurance claims electronically, by fax, or by mail. The following release gives permission to use your information to process your claim. I also authorize payment of medical benefits to Weber Chiropractic for services rendered.**

By signing this form you are giving Weber Chiropractic permission to use and disclose your health information in accordance with the directives listed above.

AUTHORIZATION AND ASSIGNMENT

- **I authorize you to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.**
- **I authorize the direct payment to you any sum I now or hereafter owe you, by my attorney, out of the proceeds of any settlement of my case, and/or by any insurance co. obligated to make payment to me or you based in whole or in part upon the charges made for services.**
- **In the event any insurance company obligated by contractual agreement to make payment to me or you for the charges made for your services refuses to make payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any company of which is believed to be correctly set forth under pertinent data and authorize you to prosecute said action in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect from insurance company proceeds, whether it be all or part of what is due, I personally owe and agree to pay you.**
- **In addition, I hereby waive the statute of limitations on collection and/or recovery in this State _____.**
- **I further agree that this Authorization and Assignment is irrevocable and ongoing till all monies owed are paid in full.**
- **This Authorization and Assignment will be continual until revoked by both parties.**

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke AUTHORIZATION, in writing at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the front desk staff of Weber Chiropractic. The written notice must contain the following information:

- **Your name, social security number, and date of birth.**
- **A clear statement of your intent to revoke this AUTHORIZATION.**
- **The date of your request; and your signature.**

You have the right to refuse to sign this AUTHORIZATION, if you refuse to sign this authorization, Weber Chiropractic will still provide service to you.

I agree with the above statements and those that I have given on the confidential patient information forms.
Name _____ Date _____
Signature _____
If a minor, or represented by another party: Name _____
Signature of Personal Representative _____

FEMALE MEDICAL HISTORY

Obstetrics History

Check box if yes, and provide number of pregnancies and/or occurrences of conditions.

□Pregnancies_____ □Caesarean_____ □Vaginal Deliveries_____

□Miscarriage_____ □Abortion_____ □Living Children_____

□Post-Partum depression_____ □Toxemia_____ □Gestational Diabetes_____

□Epidurals_____ □Induced Labor_____

Gynecological History

Age at 1st menses:_____ Frequency_____ Length_____

Painful: Yes____ No_____ Clotting: Yes_____ No_____

Date of last menstrual period: _____/_____/_____

Do you currently use contraception? Yes____ No_____ If yes, please indicate which form:

Non-Hormonal

- □ Condom
- □ Diaphragm
- □ IUD
- □ Partner Vasectomy
- □ Other (non-hormonal, please describe) _____

Hormonal

- □ Birth Control Pills
- □ Patch
- □ Nuva-Ring
- □ Implant
- □ Other (please describe) _____

Even if you are not currently using conception, but have used hormonal birth control in the past, please indicate which type and for how long. _____

_____

Do you experience breast tenderness, water retention, or irritability (PMS) symptoms in the second half of your cycle?

Yes_____ No_____

Please advise of any other symptoms that you feel are significant. _____

_____

_____

Are you menopausal? Yes_____ No_____ If yes, age of menopause_____

Do you currently take hormone replacement? Yes___ No___ If yes, what type and for how long? _____

□Estrogen □Ogen □Estrace □Premarin □Progesterone □Provera

□Other _____

Diagnostic Testing

Last PAP test: ____/____/____ Normal:_____ Abnormal:_____

Last Mammogram: ____/____/____ Breast Biopsy? Yes__ No___ Date: ____/____/____

Date of Last Bone Density ____/____/____ Results: High___ Low___ Within Normal Range___