Riverside Chiropractic Health Center

New Patient Intake Form (Ages 13-17)

Today's Date: _____

PATIENT INFORMATION:

Full Legal Name: _____Preferred Name: _____

Birth Date: _____/_____/_____ Age: _____ Sex: _____

Address: _____ City: _____State: _____ Zip Code: _____

Guardian/Main contact person: _____ Phone number: _____

Height: _____ Weight _____ How did you hear about our office? _____

Primary Care Physician Name and Phone Number: _____

EMERGENCY CONTACT:

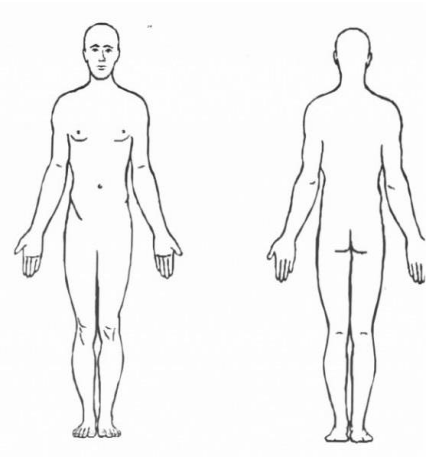
Name: _____Phone Number: _____Relationship to Patient: _____

Patient Condition:

Reason(s) or visit:

_____

Please indicate type and severity of pain/discomfort with the below key on the diagram:



Type of Pain: A=Achy S=Sharp
N=Numb C=Cramps T=Tight
Pain:
Scale 0-10 1=Mild 10=Severe

When & how did your symptoms appear?

_____

_____

_____

_____

How often do you have this pain/sensation?

☐ 0/25% of the day ☐ 26/50% of the day ☐ 51/75% of the day ☐ 76/100% of the day

HEALTH HISTORY:

What treatment have you already received for your condition?

☐ Chiropractic ☐ Physical Therapy ☐ None ☐ Other _____

List all injuries/strains/ sprains/ broken bones, how they happened and estimated dates:

_____

_____

_____

_____

_____

List all surgeries and/or hospitalizations, reasons and estimated dates:

_____

_____

Do you have any other concerns that you would like the doctor to know about?

_____

_____

_____

Patient Guardian Signature_____ Date_____

Doctor Signature_____ Date_____

Activities of Daily Living

Outcome Assessment Tool

Name:_____ Date:_____

Areas of Pain and/or Dysfunction (Please list):_____

*(If you have more than one area of pain and/ or dysfunction **ABBREVIATE** for each number on the scale of 0-10. Ex. N=Neck H=Hip LB=Low Back, etc. **ABOVE THE NUMBER**. If you have any questions please ask us.)*

	0	2	4	6	8	10
1. Pain Intensity	NO PAIN	INTERMITTENT PAIN	MILD PAIN	MODERATE PAIN	SEVERE PAIN	WORST POSSIBLE PAIN
2. Sleeping	PERFECT SLEEP	INTERMITTENTLY DISTURBED	MILDLY DISTURBED	MODERATELY DISTURBED	GREATLY DISTURBED	TOTALLY DISTURBED
3. Personal Care (washing, dressing, etc)	NO PAIN NO RESTRICTIONS	INTERMITTENT PAIN SOME RESTRICTION	MILD PAIN NEED TO GO SLOW	MODERATE PAIN NEED HELP	STRONG PAIN NEED HELP	SEVERE PAIN NEED 100% HELP
4. Travel (driving, etc)	NO PAIN ON LONG TRIPS	INTERMITTENT PAIN ON LONGTRIPS	MILD PAIN ON LONG TRIPS	MODERATE PAIN ON LONG TRIPS	MODERATE PAIN ON SHORT TRIPS	SEVERE PAIN ON SHORT TRIPS
5. Work	CAN DO USUAL WORK + EXTRA	CAN DO USUAL WORK, NO EXTRA	CAN DO 75% OF USUAL WORK	CAN DO 50% OF USUAL WORK	CAN DO 25% OF USUAL WORK	CANNOT WORK
6. Recreation	CAN DO ALL ACTIVITIES	CAN DO MOST ALL ACTIVITIES	CAN DO MOST ACTIVITIES	CAN DO SOME ACTIVITIES	CAN DO A FEW ACTIVITES	CANNOT DO ANY ACTIVITES
7. Frequency of pain	NEVER ANY PAIN	OCCASIONAL PAIN 10% OF DAY	OCCASIONAL PAIN 25% OF DAY	INTERMITTENT PAIN 50% OF DAY	FREQUENT PAIN 75% OF DAY	CONSTANT PAIN 100% OF DAY
8. Lifting	NO PAIN WITH HEAVY WEIGHT	INTERMITTENT PAIN WITH HEAVY WEIGHT	↑ PAIN WITH HEAVY WEIGHT	↑PAIN WITH MODERATE WEIGHT	↑PAIN WITH LIGHT WEIGHT	↑PAIN WITH ANY WEIGHT
9. Walking	NO PAIN ANY DISTANCE	↑PAIN AFTER LONG DISTANCE	↑ PAIN AFTER 1 MILE	↑ PAIN AFTER ½ MILE	↑PAIN AFTER ½ HOUR	↑PAIN WITH ALL WALKING
10.Standing	NO PAIN AFTER SEVERAL HOURS	↑PAIN AFTER SEVERAL HOURS	↑PAIN AFTER 2 HOURS	↑PAIN AFTER 1 HOUR	↑ PAIN AFTER ½ HOUR	↑PAIN WITH ANY STANDING
11. Other : _____ Please fill in if There is another ADL That is not listed	NO PAIN AFTER SEVERAL HOURS	↑ PAIN AFTER 3 OR MORE HOURS	↑PAIN AFTER 2 HOURS	↑PAIN AFTER 1 HOUR	↑PAIN AFTER ½ HOUR	↑ PAIN WITH ANY_____

Patient Signature: _____ Dr. Initials: _____ Date: _____

Date: _____

Dear Insurance Carrier,

I understand you may be holding up payment of my claims because you are waiting to update your records regarding my status and my coverage. The following is my updated information:

Name of patient _____ SS# _____ DOB _____

Insured Information:
Insured Name_____ Policy ID#_____ Relation to Insured_____

PLEASE CHOOSE SECTION THAT APPLIES & CHECK ONLY 1 LINE

Spouse / Partner:

_____ I am the patient AND the insured AND I have no other insurance coverage
_____ I am the patient, BUT the insured is my spouse/partner _____. I am not employed and therefore have no other insurance coverage of my own.
_____ I am the patient, BUT the insured is my spouse/partner _____. I am employed at _____ but have no coverage through that employer.
_____ I am the patient & have my own coverage - the following is my coverage information:
Primary Ins _____ Insured Name: _____ Insured DOB: _____
Secondary Ins _____ Insured Name: _____ Insured DOB:_____

_____ _____
Signature Date

Dependent Child Over 18: (covered under parent's policy)

_____ I am a FT student & have 1 policy. Attached is my current school schedule.
Primary Ins _____ Insured Name: _____ Insured DOB: _____
_____ I am a FT student & have 2 polices. Attached is my current school schedule.
Primary Ins _____ Insured Name: _____ Insured DOB: _____
Secondary Ins _____ Insured Name: _____ Insured DOB:_____
**determining primary/secondary is usually based on the 'birthday rule'.

_____ _____
Signature Date

Dependent Child Under 18: (covered under parent's policy)

_____ I am a minor dependent and only covered under one policy :
Primary Ins _____ Insured Name: _____ Insured DOB: _____
_____ I am a minor dependent and covered under two policies :
Primary Ins _____ Insured Name: _____ Insured DOB: _____
Secondary Ins _____ Insured Name: _____ Insured DOB:_____
**determining primary/secondary is usually based on the 'birthday rule'.

_____ _____
Parent or Guardian Signature Date

Revised 10/25/08

DISCLOSURE OF INSURANCE PARTICIPTATION STATUS AND FEES

The laws of the state of New Jersey and New Jersey Department of Health and New Jersey Department of Banking and Insurance require that the health care professional inform patients of the heath care plans in which the professional participates in and the facilities with which the professional is affiliated with. In compliance with these laws, the undersigned patient is hereby notified, in writing that:

Health Plans Our Practice Participates With:

Name:	Address:
Blue Cross Blue Shield	820 Newark NJ 07101
United Health Care	PO Box 740800 Atlanta Georgia 30734
Medicare	PO Box 3034 Mechanicsburg PA 17055

Mandatory Disclosures: **PLEASE INITIAL ALL**

1. I understand that the health care professional that I am seeking healthcare services from is "out of network" with and does not participate with my health insurance plan;

Out-Of-Network Patients **In-Network Patients**

Patient initials:____ [or] N/A_____

2. I understand that the amount or estimated amount the health care professional will bill me or the covered person for the services is available on request.

Out- Of Network Patients **In-Network Patients**

Patients initials_____ [or] N/A_____

3. I understand that I may request from the provider an estimated charge for the services proposed and the Current Procedural Terminology (CPT) codes associated with that service, and the health care professional shall disclose to me, the patient, in writing the or amount estimated amount that the health care professional will bill the covered person for the service, and the CPT codes associated with that service, absent unforeseen medical circumstances that may arise when the health care service is provided;

Out-Of-Network Patients **In-Network Patients**

Patient initials_____ [or] N/A_____

4. I understand that I will have a financial responsibility applicable to health care services provided by an out-oh-network professional, excess of my in-network copayment, deductible, or coinsurance and that I may be responsible for any costs in excess of those allowed by my health benefits plan.

Out-Of-Network Patients **In-Network Patients**

Patient initials _____ [or] N/A_____

5. I have been advised that I should contact my health insurance plan or administrator for further consultation on those costs.

Out-Of-Network Patients **In-Network Patients**

Patient initials _____ [or] N/A_____

The health care provider and patient both acknowledge and agree that receipt or acknowledgment by patient of these disclosures shall not waive or otherwise affect any protection under existing statues or regulations regarding in-network health benefits plan coverage available to the patient under the law.

The heath care provider father acknowledge and agrees that, if in between the time these disclosures are not made to the patient and the time and health care services takes place, the network status of any of the health care professionals changes as it related to the patient's health benefits plan, the professional shall notify the patient promptly.

Acknowledgment of Receipt of Disclosures – **OUT-OF -NETWORK PATIENTS**

I, the undersigned patient, acknowledge receipt of this disclosure form from my health care provider, and have read it and understand the contents. I have discussed my option to obtain treatment with other health care providers, service providers, or at alternative health care facilities that may participate with my health plan and I waive the right to do so and wish to obtain my treatment at this office with full notice of these disclosures and potential cost sharing consequences. I certify that I am at least 18 years of age, competent, not under the influence of any drug, alcohol, or other substance that would impair my ability to understand these disclosures, am not being coerced to sign this disclosure, and do so upon my own free will.

By: _____ Date _____

Print Name: _____

Acknowledgment of Receipt of Disclosure – **IN-NETWORK PATIENTS**

I, the undersigned patient, acknowledge receipt of this disclosure form from my health care provider, and have read it and understand the contents. I understand that currently my out of pocket expenses will be limited to those described in my insurance policy and the contractual obligations between the health care provider and my insurance carrier. The health care provider further acknowledges and agrees that, if, between the time these disclosures are made to the patient and the time the health care service tales place, the network status of any health care professionals' changes as it relates to the patients health benefits plan, the professional shall notify the patient promptly. I certify that I am at least 18 years of age, competent, not under the influence of any drug, alcohol, or other substance that would impair my ability to understand these disclosures, am not being coerced to sign this disclosure, and do so upon my own free will.

By: _____ Date_____

Print Name: _____

ASSIGNMENT OF BENEFITS/ERISA AUTHORIZATION FORM

Financial Responsibility

I have requested professional services from Riverside Chiropractic on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____	_____
Patient	Date
_____	_____
Policyholder/Insured	Date

Informed Consent to Chiropractic Care

WHAT INFORMED CONSENT IS

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

POSSIBLE TREATMENT MODALITIES

Chiropractic care centrally involves what is known as a chiropractic adjustment. There will most likely be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being. The adjunctive procedures depend upon your specific circumstance and may include but are not limited to: ultrasound, hot/cold packs, electrical stimulation, laser, traction, exercises and other physical modalities.

RISKS & BENEFITS

It is important that you understand, as with all health care approaches, **results are not guaranteed, and there is no promise to cure**. As with all types of health care interventions, there are some risks to care, including, but not limited to: **muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains**.

ALTERNATIVES

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, surgery, **or no care at all**. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

PATIENT ACKNOWLEDGMENT & WITNESS

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name:_____ Signature:_____
Date:_____

Witness Name:_____ Signature:_____
Date:_____

Riverside
CHIROPRACTIC
HEALTH CENTER

Katherine Holstein Reid, DC
325 W. Water St, Suite 2 Toms River, NJ 08753
Ph: 732-569-3241 Fax: 732-569-3278
DrKatie@DrKatieHolstein.com
www.DrKatieHolstein.com

Maximizing Results:

- It is recommended to be as relaxed as possible during your adjustments for best results.
- Try to wear loose fitting clothing and minimal jewelry when possible
- Please remove shoes, belts and everything out of your pockets before getting on the adjustment table
- Please refrain from wearing any colognes or perfumes because Dr. Katie is allergic

Thank you for your cooperation! Your best results are our top priority!

No Show/Cancellation Policy:

Our appointments run every 15 minutes, therefore please be on time. Please allow yourself enough time to check in prior to your appointment time. Patients who do not show up or fail to give 12 hours cancellation notice for their appointment will be charged a $30 fee.

Insurance Benefits:

We do our best to know your insurance benefits ahead of time to avoid surprises, however, it is ultimately the patient's responsibility to know what their chiropractic benefits are. If you have limited or no insurance benefits we have cost effective payment arrangements available.

Patient Name: _____

Patient Signature: _____ Date: _____

Witness Name: _____

Witness Signature: _____ Date: _____