Patient Intake Information

Date: _____

(Legal) First Name	(Legal) MI	(Legal) Last Name	DOB	Age
			/ /	

Mailing Address: _____

Home Phone: _____ **Cell Phone:** _____ **Cell Carrier:** _____

Email: _____ is this a **HOME** email or **WORK** email? **(circle one)**

Contact Preference: (circle one) Home Ph// Work Ph//Cell Ph// Email// Postal Mail **Gender:** _____

Social Security#: _____ **Marital Status:** __ S __M __W __D **Spouse:** _____

Occupation: _____ **Employer:** _____ **Work Phone:** _____

Emergency Contact/Relationship: _____ **Phone:** _____

Who referred you to our office? _____

Insurance information: *A copy of your insurance card(s) will be made, in addition, please complete the information requested below:*

Insurance Company Name: _____

Are you the policy holder: ____ yes ____ no if no, please list the policy holder information below:

Policy holder's full name	Relationship to you	Date of birth

Is today's visit due to a work related injury? Y/N – If yes, see receptionist for further instructions
Is today's visit due to an auto accident: Y/N – if yes, see receptionist for further instructions

There may be some things that your insurance company does not cover but we can discuss reasonable and affordable payments options. If you have a problem that we can help, and we decide to accept your case, are you willing to pay out of pocket to reach your health care goals? _____ **YES** _____ **NO**

Patient Signature: _____ **Date:** _____
(Patient/Parent/Guardian)

Medications: Please list the medications you are currently taking. Please be as specific as possible.

_____

_____

_____

_____

_____

First Name MI Last Name

CHIEF COMPLAINT

Please give a brief description of the problem(s) you are experiencing:

When did your pain begin? _____ Is/Are the problem(s) getting better or getting worse? _____

Are you seeing any other providers for this or any other problem(s) or health condition(s)? ____ Y ____ N
Please list the problem(s), date problem(s) began and Provider treating you for the condition:

PLEASE REFER TO THE PAIN DIAGRAM TO INDICATE LOCATION/SEVERITY OF YOUR PAIN

PAST HEALTH HISTORY

Have you ever had any major illness, injuries, broken bones, hospitalizations, or surgeries? If yes, please list them:

Have you had any diagnostic imaging i.e. XRAYS, MRI, CT scan, bone scan, etc. in the past 5 years? If yes, please list:

Is there any history of significant family health problems? If yes, please list:

Do you exercise regularly? ____ Y ____ N - If yes, how many hours per week and what activities:

Weight _____lbs. Height _____ Have you recently lost or gained weight? _____ Y _____ N

Do you smoke? _____ Never ____ Former Smoker ____Current/every day Smoker _____ Current/some day smoker

Circle any conditions you have/had:

Arm/Shoulder pain	Headache/Migraine	Leg Pain	Low back pain	Neck pain
Herniated Disc	AIDS/HIV	Allergies	Anxiety/Depression	Arthritis
Asthma	Bladder Issues	Cancer	Chronic Fatigue	Deafness
Diabetes	Digestion Issues	Earache	Ear Ringing	Epilepsy
Heart Disease	High Blood Pressure	Insomnia	Irregular Cycle	Kidney Issues
Osteoporosis	Poor Circulation	Prostate Issues	Rheumatoid Arthritis	Sciatica
Seizures	Shingles	Sinus Infections	Stroke	Thyroid Issues
TMJ	Venereal disease	Vertigo/Dizziness		

Other: _____

Thank you for your cooperation!

West-Land Clinic of Chiropractic Financial Policies

Our commitment to you is the best chiropractic healthcare possible. If you have insurance, we are anxious to help you receive the maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policies. Chiropractic care is covered under most insurance plans. Most of our patients having health or accident insurance will fall under one of the plans discussed below. We ask that you read the particular plan that applies to your situation. Please do not hesitate to ask if you have questions. ***In all cases, you are ultimately responsible for your bill.***

- **GROUP OR INDIVIDUAL INSURANCE PLANS:**
  When possible, we will call your insurance company to verify the benefits available to you. We cannot guarantee what your insurance company will pay, but will wait for payment on the portion covered by your insurance if we are an in-network provider. Until we have the completed, correct, and necessary information regarding coverage, you will be required to pay for your care. By signing below you will be giving us the authorization to release information to your insurance company to properly process your paperwork. We will expect payment from you on any non-covered services, deductible or co-pay amounts. You must understand and agree that health insurance policies are an arrangement between insurance provider and carrier. Therefore, you clearly understand and agree that all services rendered to you are charged directly to you and you are personally responsible for payment. We gladly accept check, cash, MasterCard, Visa or Discover. A late fee of $10 per month will appear on any accounts that remain unpaid after 60 days from initial billing period. Delinquent accounts will be handled by an outside collection agency if unpaid after 90 days from initial billing period. In the event that a payment should come to you, you are expected to bring the endorsed check and Explanation of Benefits to the office.

- **MEDICARE:**
  We do accept assignment from Medicare. Only spinal manipulations (adjustments) are covered under Medicare benefits. Medicare pays 80% of the allowable fee once the deductible has been met. Please inform us if you have "medigap" or secondary insurance in addition to Medicare.

- **SECONDARY INSURANCE:**
  Please inform us if you have a second insurance that may provide coverage.

- **"ON THE JOB INJURY" – WORKERS COMPENSATION:**
  If you are injured on the job, your care should be paid for under your employer's worker compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the insurance carrier to be billed. You are responsible for communication regarding any claim changes or updates. If you do not provide this information, payment for services will be solely your responsibility.

- **PERSONAL INJURY OR AUTO ACCIDENT:**
  Although you are ultimately responsible for your charges, we will make every effort possible to wait for your insurance to make payment on your account. If no payment is received within 60 days, or if we must wait for a settlement or a third payer, a payment plan will be arranged for you. In the event that payment comes to you from the insurance company or your attorney achieves a settlement, we expect payment immediately. If you are released from care or noncompliant with medical recommendations, the account balance is due within 90 days. You are responsible for payment of all services on your account.

- **PATIENTS WITHOUT INSURANCE:**
  Payment is expected as services are rendered unless prior financial arrangements have been made. We are happy to accept your check, cash, MasterCard, VISA or Discover.

- **TO ALL PATIENTS:**
  1. We need a photo ID for billing and insurance purposes.
  2. **Payment is required at the time of service.** We will be happy to accept your check, cash, MasterCard, Visa or Discover.
  3. **Late fees of $10 per month will appear on all accounts over 60 days from initial billing period.**
  4. Accounts with no activity for 90 days may be forwarded for further collection action.
  5. Durable Medical Equipment, including, but not limited to rextraction, fulcrums and pillows, are non-covered items that require payment in full at time of purchase.

I HAVE READ AND AGREE TO THE TERMS OUTLINED ABOVE

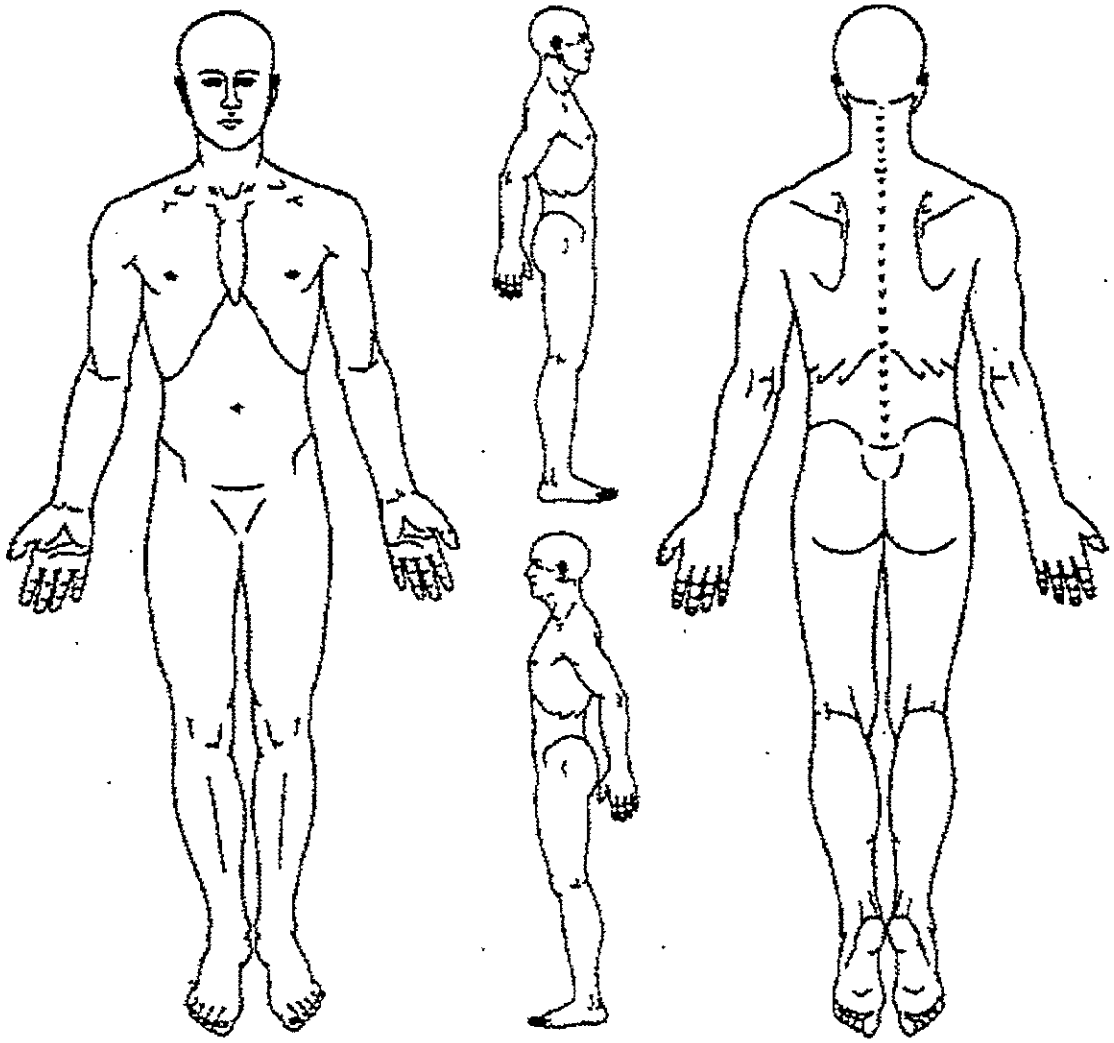
PATIENT/PARENT/GUARDIAN SIGNATURE/PRINTED NAME _____ DATE _____

Name:_____ Date:_____

PAIN DIAGRAM

On the diagrams below mark where you are experiencing pain, right now. Use the letters below to indicate the type and location of your sensations.

Key: **A** – ACHE **B** – BURNING **N** – NUMBNESS
P – PINS & NEEDLES **S** – STABBING **O** - OTHER



PAIN SCALE

Rate the severity of your pain by checking one box on the following scale.

No Pain — Worst Possible Pain

0	1	2	3	4	5	6	7	8	9	10

WestLand Chiropractic

HIPAA Compliance Patient Consent Form

Our notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your voicemail at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If yes, please list the name and relationship of the members allowed:

_____

_____

This consent was signed by: _____
(PLEASE PRINT NAME)

Signature: _____ Date: _____

Drs. Patrick J. Landry & Phillip A. Westerbeck
1828 Ligonier Street, Latrobe PA 15650
WestLandClinicLatrobe.com
724-532-3077