NEW PATIENT INTAKE

HEXIS CHIROPRACTIC
PRENATAL · FAMILY · PEDIATRIC

Name: _____ Date: _____

Address: _____City:_____ State:_____ Zip:_____

Home Phone (____)_____Cell (____)_____ Work (____)_____

We use text messages for appointment reminders. Who is your cell phone company? _____

Email Address: _____

Male_____ Female_____ Birth Date: _____ Age:_____

Occupation: _____Employer Name _____

Single____ Married____ Spouse's Name _____

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

YOUR HEALTH SUMMARY

What is your chief complaint?_____

Have you seen a Chiropractor before? _____ If yes, when?_____

Check all symptoms you have ever had even if they do not seem related to your current problem.

___Headaches
___Pins and needles in arms
___Ringing in ears
___Depression
___Sleeping problems
___Migraines
___Pins and Needles in legs
___Back Pain
___Numbness in fingers
___Tension
___Neck Stiffness
___Problem Urinating
___Neck Pain
___Loss of balance
___Numbness in toes
___Menstrual irregularity
___Heartburn
___TMJD
___Dizziness
___Fatigue
___Cold Feet
___Cold Hands
___Vertigo
___Shoulder Pain

Please list any medications you are taking: _____

_____

If this is due to an injury or auto accident, what is the date of injury or accident?_____

Has this problem been getting better, worse, or staying the same?_____

What activities make your condition worse? _____

Any surgeries or hospitalizations?_____

Injuries or illnesses that you have had that are not listed above:_____

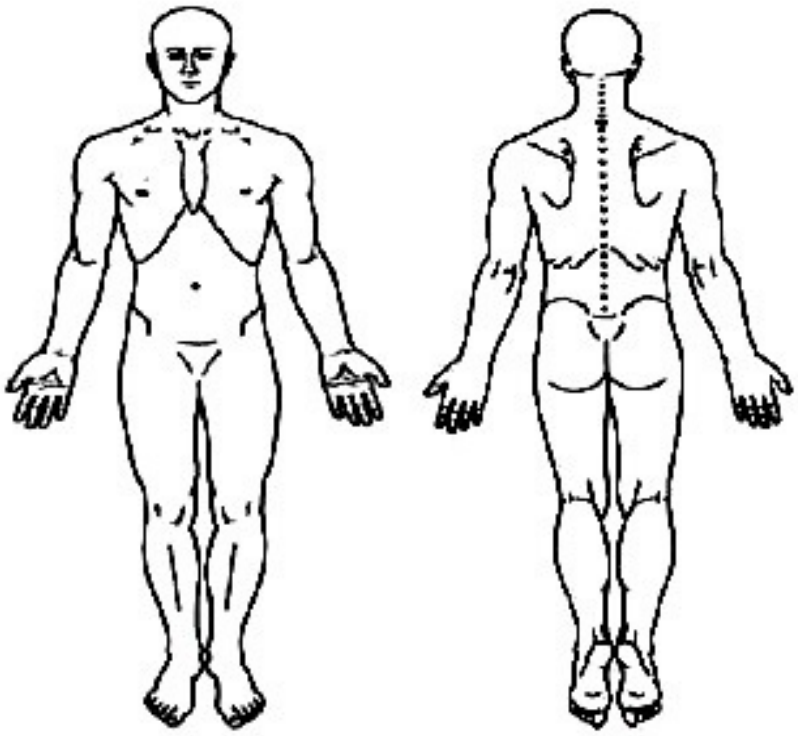
Do you have health insurance? ☐ Yes ☐ No Or a HSA account? ☐ Yes ☐ No

If so, please provide the front desk with your card so we can verify your benefits with our office.

Name of Policy Holder: _____ DOB:_____ Relationship to them_____

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, *dull, sharp, constant, off and on, when standing, when sitting, etc., etc.*

COMPLETE THESE DIAGRAMS



Type of Pain: _____

_____

_____

Frequency: _____

_____

_____

What makes it worse:_____

_____

_____

Have you had this before? Yes No

If yes, when? _____

Method of payment you plan to use for today's charges: ☐ **Check** ☐ **Cash** ☐ **Credit Card**

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE OR VERIFY A DIAGNOSIS, TYPE OF TREATMENT AND LENGTH OF TREATMENT. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. **All first visit charges are payable when services are rendered.**
2. **The fee paid for x-rays is for analysis only. Colorado state law requires we maintain your x-rays. The film itself is the property of this office. Films may be loaned to another facility with authorization only.**

PATIENT AUTHORIZATION REGARDING OUR OPEN DOOR ADJUSTING ENVIRONMENT, SIGN-IN SHEETS, TRAVEL CARD USE AND PATIENT RECORD OF DISCLOSURES.

Our office uses sign in sheets, travel cards, and provides care in an open door adjusting environment. As a result patients are in sight of each other, and some ongoing / routine details of care may be in ear shot of other patients and staff. This environment is used for on going care and is not the environment for taking patient's histories, performing examinations, or presenting report of findings. These procedures are done in a private, confidential setting. If you choose not to be adjusted in an open door adjusting environment, other arrangements will be made for you. Your signature below authorizes us to contact you at all phone numbers / addresses you list on this intake form. If you do not wish to be contacted at any listed numbers / addresses, please let us know.

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient's Signature_____Date_____

Name: _____ Date: _____

TERMS OF ACCEPTANCE

Please read below and if you have any questions, feel free to ask one of our staff members.

HEXIS CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing that, by law, we must maintain the privacy and confidentiality of your Personal Health Information (PHI). In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice, please sign and return with the rest of your paperwork. Should you want to keep a copy of this form for your records, you may ask our front desk receptionist to create a copy.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency, we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership - in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance (72 hours).
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours).

Name: _____ **Date:** _____

Signature: _____ **Date of Birth:** _____

HEXIS CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY (CONT.)

I have received a copy of Hexis Chiropractic's Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me by the front desk receptionist at my request. At this time, I do not have any questions regarding my rights or any of the information I have received.

Signature: _____ **Date:** _____

INFORMED CONSENT

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures. One of the rarest complications associated with Chiropractic cares occurring at a rate between one instance per one million to one per two million is a cervical spine (neck) adjustment causing injury to a vertebral artery, which could lead to a stroke.

I understand the risks associated with chiropractic spinal adjustments, and the other therapeutic procedures used by the practice to treat my current conditions. All my questions regarding treatment have been answered to my complete satisfaction, and I have conveyed my understanding of all risks to the doctor. After careful consideration, I do hereby consent to chiropractic care by any means, methods, and or techniques the doctor deems necessary to treat my condition(s) at any time throughout the entire clinical course of my care.

Signature: _____ **Date:** _____

AUTHORIZATION FOR X-RAYS

X-rays are utilized in the office to help locate and analyze vertebral subluxations. These x-rays are not to be used to investigate for medical pathology. The doctor(s) of Hexis Chiropractic do not diagnose or treat medical conditions; however if any abnormalities are found, they will be brought to your attention so that you can seek proper medical advice. By my signature below I am acknowledging that the doctor and/or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Signature: _____ **Date:** _____

(**Women Only) Please check the box that applies to you** - To the best of my knowledge:

I AM NOT Pregnant at this time ☐

I AM/believe I MAY BE pregnant, therefore I DO NOT Authorize HEXIS Chiropractic to X-ray me at this time. ☐

Signature: _____ **Date:** _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize Hexis Chiropractic to release all necessary information concerning my health condition to my billing company, insurance company, attorney, and/or adjuster in order to process any claim for reimbursement of charges incurred by me. In addition, I authorize Hexis Chiropractic to release any information regarding my health condition to other health care providers involved in my care. This assignment will remain in effect until revoked by me in writing. I agree that a photocopy of this form is to be considered as valid as the original. I confirm that all information I have provided is true and correct to the best of my knowledge. I confirm that I have read and fully understand this agreement and authorize Hexis Chiropractic to proceed with chiropractic tests, diagnosis, analysis, and adjustments.

Signature: _____ **Date:** _____

AUTHORIZATION OF USE OF / TAKING PICTURES

For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by Hexis Chiropractic, or anyone authorized by Hexis Chiropractic, of any and all photographs/videos which were taken of myself and my child(ren), for the purposes of promotional TV, website, social media, and/or print ad whatsoever, without further compensation to me. All negatives and positives, together with the prints shall constitute the property of Hexis Chiropractic, solely and completely. Any information voluntarily provided by a practice member shall also be used in conjunction with the above listed information for purposes previously mentioned. Confidentiality, in regards to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize Hexis Chiropractic to share this information via their website and their social media platforms including but not limited to Facebook and Instagram, and for use in the office. All other unrelated practice member information shall remain private and protected (according to Health Information and Privacy Act laws).

Signature: _____ **Date:** _____