Scott J Diamond
437 Boylston St suite 402
Boston, MA 02116
617-262-2225

Diamond Chiropractic

INTAKE FORM

First Name _____ **Middle Initial** ____ **Last Name** _____

Address Line _____

City _____ **State** _____ **Zip Code** _____

Cell Phone (_____) _____-_____ **Email** _____

Date of Birth _____/_____/_____ **Sex:** ☐ **Male** ☐**Female**

Marital Status: Single ☐ **Married** ☐ **Widowed** ☐

Occupation _____ **How did you hear about us** _____

EMERGENCY CONTACT

Contact Name _____ **Relationship**_____ **Phone (____)**_____-_____

SYMPTOMS HISTORY

Is the condition getting progressively worse? Yes No Unsure

Where specifically are the problems located?_____

Is the pain constant or does it come and go?_____

Circle the symptoms you are experiencing:
N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache

Activities difficult to perform. ❑Sitting ❑Standing ❑Walking ❑Bending ❑Lying down ❑Other

Rate the severity of your pain. (1 = mild pain or discomfort, to 10 = severe pain)_____

Are your symptoms a result of: Vehicle Accident Work Injury Other :_____

How often do you experience your symptoms?

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

What treatment have you received for your condition?
❑ Medication ❑ Surgery ❑ Physical Therapy ❑ Chiropractic ❑ Other_____

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DAILY ACTIVITIES

Do you smoke? ❑ Yes ❑ No **If yes, How much per day?**_____

On average how long do you sit before getting up? _____

How often per week do you get outside for a break? _____

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

HEALTH HISTORY

(Woman) Are you pregnant? ❑Yes ❑No **Nursing?** ❑Yes ❑No

Have you seen a chiropractor before (if yes) how long ago?_____

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

_____

_____

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PAYMENT / INSURANCE INFORMATION:

Health Insurance Carrier: _____ Insurance ID # _____

Policy Holder's Name: _____ Group # _____

1. Your health insurance should pay the cost of *covered* services provided to you, except for copayments, co-insurance and/or deductibles, which you will be expected to pay at the time services are rendered.

2. You will be responsible for paying an additional fee of **$20 per visit for non-covered services** you have elected to receive (via your signature on this practice's Non-Covered Services Waiver). Payment for those services will be due at the time services are rendered. *We do not bill health insurance plans for non-covered services.*

Examples of Non-Covered Services:

All Services Other than Chiropractic Adjustments:

- Office Visits - to evaluate & manage, re-evaluate, advise, or give counsel regarding your health.
- Physiotherapy - such as traction, neuromuscular re-education, etc.

Various Chiropractic Adjustments or Treatments:

- Non-spinal manipulation to the shoulder, arm, leg, etc.
- Maintenance & wellness care – to promote better health.

PATIENT STATEMENT AND AGREEMENT

- I have been informed by the provider indicated above in advance that the service(s) listed above that are not covered by insurance for the duration of my treatment.
- I understand and agree that I am responsible for payment of the provider's charges for these services
- I understand that this office does not bill health insurance plans for non-covered services.
- I understand that All payments are due at the time of service.

_____ _____ _____

Printed Patient Name Signature Date

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HIPAA REQUIRED FORM

I _____understand that as a part of my healthcare, Diamond Chiropractic, originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the health professionals who contribute to my care,
- A source of information for applying my diagnosis to my bill,
- A means by which a third-party payer can verify that services billed were provided.

Should it become necessary to disclose my protected information to another health provider or 3rd party payer for the above purposes, I consent to such disclosure for these permitted uses, including disclosures via fax.

To the best of my knowledge, all the information I provided is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever have a change in health. 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. Diamond Chiropractic may use my health care information and may disclose such information to my 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. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential