Payne Chiropractic
WELLNESS CENTER

NEW PATIENT INTAKE & HISTORY

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

HEALTH: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

All of these options will be explained at your report of findings. Then you will be able to begin a course of care that best fits your health goals.

Name: _____ Today's Date: ___/___/___ Age: _____ Date of Birth: ___/___/___

Mailing Address: _____ City: _____ State: ____ Zip Code: _____

Home Phone: _____ Cell: _____ Fax: _____ E-mail: _____

Gender: ❑ M ❑ F Ht: _____ Wt: _____ Marital Status: S ❑ M ❑ W ❑ D ❑ # of Children _____

Occupation: _____ Employer: _____ Work Phone: _____ Ext: _____

Spouse's Name: _____ Spouse's Occupation: _____

Spouse's Employer: _____ Spouse's Telephone (Work): _____

Date of last physical examination: _____ Doctor's Name: _____

Emergency Contact: _____ Relationship: _____ Contact Number: _____

Who may we thank for referring you? _____

Present Family Doctor: _____ Location: _____

Previous Chiropractic Care: ❑ Yes ❑ No if so, when _____ Chiropractor: _____

Have you had spinal X-Rays within the past 5 years? ❑ Yes ❑ No If so, when and where: _____

**For Females Only:* Is there any possibility that you are pregnant? ❑ Y ❑ N Date of last menses: ___/___/___

Health History

Is there a family history of:	Heart Disease	Arthritis	Cancer	Diabetes
Father's side	_____	_____	_____	_____
Mother's side	_____	_____	_____	_____

ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nervous system, that have resulted in poor health. Following your exam, your chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

Loss of Whole Body Health

Yes	No	(Birth - Present)	Patient Comment
____	____	Did /do you smoke?	_____
____	____	Did/do you drink any alcohol?	_____
____	____	Diet (Do you eat healthy foods?)	_____
____	____	Have you been in any accidents?	_____
____	____	Have you had surgery or organs removed/replaced?	_____
____	____	Drugs? (Prescription or non-prescription)	_____
____	____	Teeth/Jaw problems?	_____
____	____	Eye problems?	_____
____	____	Hearing problems?	_____
____	____	Exercise regularly?	_____
____	____	Did/do you have occupational stress?	_____
____	____	Physical stress?	_____
____	____	Mental stress?	_____
____	____	Hobby/Sports injuries?	_____
____	____	Sleeping habits (nightmares/sleeplessness?)	_____
____	____	Sleeping posture: __ Side __Stomach __Back	_____

Current Concerns Below

Health Concerns: List according to severity	Rate of Severity 1= mild 10=unbearable	When did this episode start?	Have you had this condition before?	Are symptoms constant or intermittent?
1._____	_____	_____	_____	_____
2._____	_____	_____	_____	_____
3._____	_____	_____	_____	_____
4._____	_____	_____	_____	_____

Have you ever seen other doctors for these conditions? ❑ No ❑ Yes.

If Yes: ❑ Chiropractor ❑ Medical doctor ❑ Other_____

Who?_____ When?_____ Results?_____

Other *Symptoms*:

❑ Allergies	❑ Diarrhea	❑ Hearing Loss	❑ Seizures	❑ Neck Pain
❑ Anxiety	❑ Dizziness	❑ Memory Problems	❑ Sinus Issues	❑ Chest Pain
❑ Asthma	❑ Ear Infections	❑ Nausea	❑ Sleeping Issues	❑ Arm Pain
❑ Bladder Problems	❑ Ears Ringing	❑ Nervousness	❑ Sports Injury	❑ Back Pain
❑ Constipation	❑ Fibromyalgia	❑ Poor Posture	❑ Thyroid Issues	❑ Hip Pain
❑ Irritable Bowel	❑ Fatigue	❑ Reflux	❑ TMJ	❑ Knee Pain
❑ Depression	❑ Headaches	❑ Sciatica	❑ Migraines	❑ Leg Pain
❑ Diabetes	❑ Heart Disease	❑ Scoliosis	❑ Vertigo	❑ Foot Pain

I would like to experience the following benefits from Chiropractic Care:

Check all that apply:

- ☐ Symptomatic relief of pain or discomfort
- ☐ Correction of the cause of the problem as well as relief of symptoms
- ☐ Prevention of future problems
- ☐ Healthier spine and nerve system
- ☐ Optimal health on all levels
- ☐ OTHER_____

What would a personal health goal be for you and the significance of the goal?

Ex) *Reduce headaches so I can play with my grandbabies.* _____

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to Payne Chiropractic use and disclosure of my Protected Health Information for the purpose of providing treatment to me for purposes relating to the payment of services rendered to me and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document. For purposes of this Consent, "Protected Health Information" means any information including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me. I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purpose of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice. I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information. I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

INFORMED CONSENT

We encourage and support a **shared decision making** process between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly, causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A **chiropractic examination** will be performed which may include spinal examination, palpation, specialized instrumentation, radiological examination (x-rays), scans and consultation.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered. This office uses the **Gonstead** Technique. Chiropractic care may reduce pain, increase mobility, and improve quality of life.
In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. In addition, there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences, and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of care and the treatment.

Patient's Signature _____ **Date** _____

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing, I authorize Payne Chiropractic to use and/or disclose certain protected health information (PHI) about me for treatment, payment or healthcare operations (TPO) as listed in our extended Notice of Privacy Practices.

This authorization permits Payne Chiropractic to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.) for TPO as listed in our extended Notice of Privacy Practices.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I hereby authorize the office of Payne Chiropractic to request any medical records, x-rays, MRI reports, CT scans, emergency room reports, physician reports, police reports and/or any pertinent information pertaining to my case history when necessary. I authorized release of medically pertinent information to any requesting hospital, physician, insurance company, or attorney pertaining to my case. This form does not expire unless written notice is given to Payne Chiropractic.

I do not have to sign this authorization in order to receive treatment from Payne Chiropractic. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Patient's Signature _____ **Date** _____

Practice Policies

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

Questions:
Do not hesitate to ask questions, we want you to be informed. Just as in a good marriage, proper communications is an absolute necessity. Our primary concern is to help you attain your optimum health.

Acknowledgment:
I have read and fully understand the above statements and terms of payment. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient's Signature _____ **Date** _____

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art, and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day from doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental, or other types of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self care, etc. is essential to maximal healing and optimal health through chiropractic.
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

Patient's Name (Print) _____

Patient's Signature (Parent, if minor) _____

Relationship to Patient _____ Date _____

Automobile Accident Information

Date of Accident: ___/___/___ Claim Number_____ Insurance Company: _____

Agent handling your claim: _____ Contact Number: _____

Driver of other vehicle: _____ Their Auto Insurance Name: _____

Have you retained an attorney? ____ Yes ____ No If yes, Attorney's Name: _____

Address: _____ Phone Number: _____

Did the police come to the scene of the accident? ____ Yes ____ No If yes, was an accident report filed? ____ Yes ____ No

Description of Accident (include city and street names): _____

_____

Were you taken to a hospital? ____ Yes ____ No Hospital Name & City: _____

How did you get to the hospital? _____ Were X-Rays taken? ____ Yes ____ No

If yes, what was X-Rayed? ____ Head ____ Neck ____ Upper Back ____ Mid-Back ____ Lower Back

In your own words, please describe the accident: _____

Payne Chiropractic
WELLNESS CENTER
Helping families unlock their full potential

Doctor's Talk

All new patients are required to attend a Doctor's Talk within the first week of starting care. Your spouse, friend, or loved one is invited to attend as well. ON the night of your appointment you will have your:

Dr. Alan Payne, D.C. **At 6 P.M. Tuesday**		**Dr. Ben Schleeter, D.C.** **At 6 P.M. Wednesday**	
	Listen Only		**Listen Only**
Group Session Slideshow First Adjustment Review your X-rays/Scans	Group Session Slideshow ONLY	Group Session Slideshow First Adjustment Review your X-rays/Scans	Group Session Slideshow ONLY
_____ *Patient's Signature*		_____ *Patient's Signature*	

Our goal is to teach you how to stay healthy naturally and to get the most of each adjustment. This is the only appointment that is required in the evening and any other appointments may be scheduled when they are most convenient for you. Please plan on spending an hour and a half for this class.

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I have read a copy of Payne Chiropractic Wellness Center HIPAA Policy.

_____ _____

Patient's Signature *Date*

Good Faith Estimate from Payne Chiropractic Wellness Center for Services rendered by: Dr. Alan Payne, Dr. Benjamin Schleeter or Dr. Haley Fine.
Group NPI: 1083633200
Address: 4014 Commons Drive W. Unit 114 Destin, FL 32541
Service: Initial Evaluation (x-rays and scans) and future adjustment

DX Code:		
	Head subluxation	99.00
	Cervical subluxation	99.01
	Thoracic Subluxation	99.02
	Lumbar Subluxation	99.03
	Sacrum Subluxation	99.04
	Pelvic Subluxation	99.05

Quantity: 1

Service Code:		
72084	X-rays	$100.00
93740	Scans	$ 35.00
98941	Adjustment	$ 60.00

Expected Cost for first visit (Initial Exam) without adjustment: 72084: $100.00 93740: $35.00
Total: $135

Future Adjustment: 98941: $60
Total: $60
Initial Exam with First Adjustment Total: $195

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include and unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill. If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill. You may contact the health care provider or facility listed to let them know the bill charges are higher than the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount. To learn more and get a form to start the process, go to https://www.cms.gov/nosurprises/consumers or call 1-800-985-3059. For questions or more information about your right to a Good Faith Estimate or to dispute the process, visit http://www.cms.gov/nosurprises/consumers or call 1-800-985-3059. Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

Patient Signature_____Date_____

Patient Printed Name: _____