

Steele Chiropractic New Patient Intake Form

Patient Name: _____ Date: _____

Address: _____ City/State/Zip: _____

Primary Phone: _____ Secondary Phone: _____

DOB: _____ Sex: Male or Female SSN#: _____

Occupation: _____ Employer: _____ Spouse Name: _____

Patient Condition: _____ How did you hear about us: _____

Reason for visit: _____

When did symptoms start? _____ Experienced before? yes no

Improvement: better worse same

Rate pain on a scale of 1(least pain) to 10(severe pain) _____

Type of pain: dull ache sharp/stabbing shooting tightness burning tingling

numbness radiating to _____

Frequency: intermittent occasional frequent constant

What makes it better: ice heat pain meds massage rest stretching nothing

What makes it worse: sitting stand bend lift walking exercise work nothing

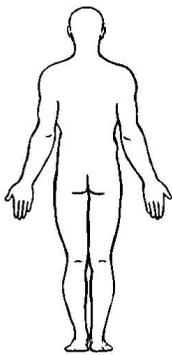
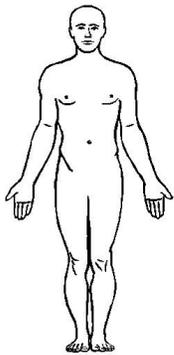
daily routine recreation sleep other _____

Previous treatment: medications surgery therapy chiropractic

Previous x-rays or MRIs and findings: _____

Mark pain area on the drawing

About You:



Height: _____ Weight: _____

Current Meds (name and reason): _____

Any Surgeries (birth to present): _____

Any Allergies: _____

Pregnant? Yes No

Preferred Language: _____ Race: _____ Ethnicity: _____ Smoking Status: _____

Medical History:

- General:** Allergies headaches/migraines dizziness fatigue fainting/seizures
 weight loss/weight gain depression cancer (type) _____
 HIV/AIDS thyroid problems liver/gallbladder problems drug/alcohol dependence
 diabetes eczema, dermatitis, psoriasis

- Muscle/Joint:** arthritis RA neck pain mid back pain lower back pain
 joint pain (i.e. knee) _____
 scoliosis osteopenia/osteoporosis rib pain sprain/strain fibromyalgia

- Cardiovascular:** high blood pressure heart attack stroke rapid heartbeat chest pains
 aneurysm poor circulation

- Neurological:** concussion sciatica right left pinched nerve arm/hand tingling

- GI:** constipation/irregular bowel habits diarrhea IBS Crohn's Celiac's ulcer
 heartburn/acid Reflux abdominal pain hemorrhoids

- Respiratory:** asthma emphysema chronic cough drainage

- Genitourinary:** frequent/painful urination bladder infection kidney stones prostate problems
 loss of bladder control PMS Endometriosis
 Profuse/irregular menstrual flow Breast lumps

- EENT:** chronic sinusitis difficulty swallowing ringing in the ears/tinnitus vision problems
 ear infections

Any other health concerns not listed: _____

Family History: check box and indicate which relative(s)

- Cancer _____ Heart problems _____
Diabetes _____ Rheumatoid arthritis _____
Lung problems _____ Chronic back problems _____
Chronic headaches _____ High blood pressure _____

Authorization:

I affirm that the information I have given is correct and accurate to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____

INFORMED PATIENT CONSENT

Patient Name:

Account #:

- My signature below indicates that I understand that if I am accepted as a patient of STEELE CHIROPRACTIC, I am authorizing them to proceed with any further treatment that may be necessary. I understand that there are risks that can be associated with care including stroke, increased nerve sensitivity/numbness, and increased muscle and joint pain. I also understand that any risks involving chiropractic treatment will be explained to me in depth upon request.

_____ staff initials

Patient Signature **OR** Parent/Guardian/Personal Representative Signature Date

Printed Name and Relationship to Patient

- My signature below indicates that I have been provided with a copy of the Notice of Privacy Practices for Steele Chiropractic and have read and understood its content.

Patient Signature **OR** Parent/Guardian/Personal Representative Signature Date

Printed Name and Relationship to Patient

BUSINESS/FINANCIAL BILLING ARRANGEMENTS

_____ **NO INSURANCE/PRIVATE PAY:** Payment in full is expected at the time of service.

_____ **COMMERCIAL INSURANCE:** As a service to our patients, Steele Chiropractic accepts assignment of insurance benefits and bills the insurance company for services provided at our office. Insurance is a contract between you and your insurance company. You will be responsible for any deductible, coinsurance and copays. Copays are expected to be paid at the time of service. Failure to present the correct insurance information at the time of your appointment may result in the entire balance becoming your responsibility. This also includes returning requests of information to your insurance company in a timely manner. While we do our best to estimate your insurance benefits, the insurance company makes the final determination on your benefits and coverage. If we are out of network with your insurance company, you are responsible for any portion of the charges not covered by them.

_____ **MEDICARE:** We are a participating provider with Medicare and therefore agree to bill and accept assignment from Medicare. Chiropractic manipulations to the spine to improve an injury or health condition are considered medically necessary and are the only service that is covered by Medicare. Medicare does not cover maintenance manipulations, manipulations to an extremity, exams, therapies or supplements and supplies at this office. I understand that if I do not have a supplemental insurance, I will be responsible for all deductible, coinsurance, and non-covered services at this office. If you do have a Medicare supplemental policy, most will cover the Medicare coinsurance. If you have chosen additional Riders on your policy, it may cover deductible services as well. Any supplemental plans written in the state of Wisconsin also follow the Wisconsin State Mandate, meaning many of them will cover maintenance manipulations, manipulations to an extremity, exams, and therapies.

_____ **MEDICARE ADVANTAGE PLAN:** We are a participating provider with many Medicare advantage plans, and we accept assignment of benefits for services provided at our office. Most of these plans follow Medicare guidelines, and therefore only cover chiropractic manipulations to the spine to improve an injury or health condition. They normally do not cover maintenance manipulations to the spine, manipulations to an extremity, exams, or therapies. I understand that I will be responsible for all deductible, coinsurance, copays, and non-covered services at this office.

_____ **STATE MEDICAL ASSISTANCE/FORWARDHEALTH:** We are a participating provider with Wisconsin State Medical Assistance and agree to bill and accept assignment of benefits for the services provided at our office. Chiropractic manipulations to the spine and exams are the only services covered by Medicaid, and they are limited to 20 visits per condition. Medicaid does not cover maintenance manipulations to the spine, manipulations to an extremity, therapies, or supplements and supplies at this office. I understand that I am responsible for all copays and non-covered services at this office.

_____ **WORKERS COMPENSATION/AUTO ACCIDENT:** We agree to bill and accept assignment of benefits from your workers compensation or auto carrier. I understand that opening a claim does not guarantee acceptance of fault nor

does it guarantee payment. It can also take a long time for settlement to be reached in these cases, and some companies will not pay until settlement has been reached. In these circumstances, I understand I may be asked to begin making payments on my account. I also understand that I am responsible for all charges that are denied or non-covered by my insurance carrier.

- PAYMENT is expected at the time of service, unless other arrangements have been made.
- INSURANCE is a contract between the patient and the insurance company and therefore, it is the responsibility of the patient to make sure the account remains current. This includes presenting correct insurance information at the time of service and returning any and all information necessary to the insurance company to get their claims processed. While we will do everything, we can to assist in getting your claims paid and processed, you are ultimately responsible for the services received at this office.
- Patients involved in LITIGATION, WORKERS COMPENSATION, OR AUTO ACCIDENT cases are ultimately responsible for the services received at this office.
- When asking us to bill any insurance, you are acknowledging that the insurance company will pay this office directly for any covered services provided by this office.
- If there is a patient balance, we will send you a monthly statement. Patients are responsible for all charges for services rendered and supplies provided by this office. Payment in full is due within 30 days of receipt of this statement, unless other financial arrangements have been made.

By signing this agreement, I acknowledge that I understand and agree to the policies and terms contained herein.

Patient Signature OR Parent/Guardian/Personal Representative Signature

Date

Printed Name/Relationship to Patient

Printed Patient Name and Chart #

Patient Consent for Electronic Reminders

Patients at Steele Chiropractic may be contacted via text messaging to be reminded of an appointment. If at any time I provide a phone number at which I may be contacted, I consent to receive appointment reminders via text from Steele Chiropractic.

_____ (Patient initials) I consent to receive text messages from Steele Chiropractic on my cell phone. I understand that this request to receive text messages will apply to all future appointment reminders unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders is _____.

Steele Chiropractic does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).



Patient Printed Name and Chart #: _____

Parent/Representative Signature: _____ Date _____

Patient Signature _____ Date _____

Revocation:

___ I hereby revoke my request to receive any future appointment reminders via text messages.

NOTE: This revocation only applies to communications from this Practice.