New Patient Intake

Welcome to DeFalco Family Chiropractic!

We are honored you chose us to evaluate your condition. So that we may file your insurance forms, please fill out the personal information below. Thank you!

Personal Information:

Patient Name: _____ Todays Date: _____

Date of Birth: _____ Age: _____ SSN _____ Sex: M or F Marital Status: S M D W

Address: _____

City: _____State:_____ Zip:_____

Cell Phone: _____ Text Msg Appointment Reminder: Y or N

E-Mail: _____

Employer Name: _____ Occupation: _____

Emergency Contact: _____ Relationship:_____ Phone: _____

Referral Information:

How did you find out about us / who referred you? _____

Primary Care Physician (Name, phone, location): _____

_____

Insurance Information:

Have you called your PCP for a referral if needed? ☐ Yes ☐ No ☐ Unsure if I need one.

ALL Fallon Health Plans & Tufts Medicare plans need a referral. Other insurances vary.

I understand that if I do not obtain a referral/written order dated for my first date of service, I will be financially responsible for the denied claims. _____ (initial) (more details regarding our financial agreement can be found on page 3)

Primary Insurance Company _____ Member ID# _____

Secondary Insurance Company _____ Member ID# _____

Chiropractic Patient History

Description:

What brings you in today? _____

What caused the onset? When did it start? _____

What, if anything makes it better or worse ?_____

How much has the complaint interfered with daily life? _____

On a scale of 0 (No Pain) to 10 (excruciating), please rate your pain. _____

How often do you experience this issue? ☐ Constantly (100%) ☐ Frequently (75%) ☐ Occasionally (50%) ☐ Intermittently (25%)

Describe the sensation of your complaint? Sharp, Shooting, Numbness, Tingling, Dull Ache, Burning, Throbbing, Other_____

Previous Treatment:

Who have you seen for this condition? ☐ Medical Doctor ☐ Physical Therapist ☐ Chiro ☐ Other _____

Social & Prior History: (please list any other past health issues or conditions, please include any surgeries)

Do you exercise, how often? _____ How many hours of sleep do you get a night? _____

Describe your diet: _____

Describe your job: _____

Do you have a pacemaker? _____ Are you Pregnant? _____

Musculoskeletal Issues: _____

Neurological Issues:_____

Head, Eyes, Nose, Throat Issues: _____

Cardiovascular or Respiratory Issues: _____

Bladder or Bowel Issues: _____

Skin Issues: _____

Autoimmune Conditions: _____

Medication History: (Please list any medications or supplements you are currently taking.)

_____

_____ _____ _____

Printed Name **Signature** **Date**

CANCELLATION POLICY - DFC requires a 24-hour cancellation notice.

There is a $25.00 service fee for **NO-SHOWS or CANCELLATIONS without 24 hours' notice for any and all apointments**. This charge is NOT covered by your medical insurance and is billed directly to the client and will be collected at the time of the next scheduled appointment. Repeated missed appointments may warrant discontinuance of care.

FINANCIAL AGREEMENT

I understand that health insurances, worker's compensation, motor vehicle/personal injury and other third-party payer policies are arrangements by and between insurance carriers and the subscriber. Furthermore, I understand that it is my responsibility to be aware of the benefits available to me through my insurance carrier and that it is in my best interest to call my health insurance company and verify my individual benefits.

I understand that I am responsible for securing a REFERRAL, PRE-AUTHORIZATION and/or CLAIM NUMBER from my health insurance company, Workers Compensation Carrier and/or Motor Vehicle/Personal Injury Third Party Payer. If this information is not provided to DeFalco Family Chiropractic (hereinafter DFC) at the time of my FIRST VISIT, I agree that I am responsible to pay out-of-pocket for the services rendered to me until such time the information (referral, claim number, pre-authorization, and prescription) is provided to DFC.

1. I authorize the release of any and all medically necessary information to process all claims related to services rendered at DFC.

2. I authorize payment of medical benefits directly to DFC for professional services rendered.

3. I understand that payment for all services rendered to me is ultimately my individual responsibility.

   - Co-payments and payments toward deductibles/co-insurances are due and payable at time of service.

   - All unpaid balances for professional services are due within 30 days of discharge from services at DFC. If payment is NOT received within 30 days, all balances are subject to an 18% finance charge annually.

4. There is a $35.00 returned check fee.

5. If there are any changes to your Health Insurance Benefits or Carrier, it is your responsibility to notify and update DFC within 10 business days.

6. If your injury is related to a Motor Vehicle Accident, Personal Injury or Worker's Compensation Injury, it is your responsibility to inform DFC.

7. It is your responsibility to inform DFC if you have secondary insurance.

   It is DeFalco Family Chiropractic responsibility to provide quality patient care, verify each patient's insurance benefits, to file insurance claims as a courtesy to the patient. A 60-day period will be extended for pending insurance payment, after which the patient may be held responsible for the entire balance.

I have read and agree with all the provisions within DFC's Cancellation and Financial Policy. I further acknowledge that all the information given, whether oral or written by me to DeFalco Family Chiropractic is true.

_____ _____ _____

Printed Name **Signature** **Date**

Informed Consent to Chiropractic Treatment

The Nature of Chiropractic Treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular incident could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular incident has been estimated at one in twenty million and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other Treatment Options: May include over-the-counter analgesics, prescription medications, injections, and surgery.

Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

No Warranty: I understand that my doctor at DeFalco Family Chiropractic, cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my doctor will share with me his opinion regarding potential results from chiropractic treatment for my condition and will discuss treatment option with me before I consent to treatment.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

_____	_____	_____
Printed Name	**Signature**	**Date**

Consent to Treat Minor – For use when applicable.

I hereby authorize DeFalco Family Chiropractic, Doctor of Chiropractic, to administer chiropractic care, as deemed necessary, to my child.

_____	_____	_____
Name of Child	**Signature (Parent or Guardian)**	**Date**

HIPAA Disclosure Form

Purpose of Consent

This Consent for the use and/or disclosure of personally identifiable health information is made pursuant to the requirements of 42 C.F.R. §164.506, which sets out the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by DeFalco Family Chiropractic (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Consent, I understand and acknowledge that I have the right to review the Privacy Notice prior to signing this Consent.

3. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me, but if the Practice agrees to such a requested restriction, it will be bound by that restriction until I notify it otherwise in writing. I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (**leave blank if no restrictions**): _____
   _____

4. I understand and acknowledge that I may revoke this Consent at any time by sending a written revocation to the Practice at the address set forth in (3) above. However, I also understand and acknowledge that if I revoke this Consent, my revocation will not be effective to the extent that the Practice has already acted action in reliance on this Consent.

   I understand the foregoing provisions, and I wish to sign this Consent authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

By signing this form, I acknowledge that I have reviewed and agree to DFC's use and disclosure of my private healthcare information (HIPAA) for treatment, payment, and health care operations.

_____ _____

Patient or Guardian Signature Date