Love Chiropractic
Dr. Steve Love | Dr. Tiffany Love

Electronic Health Records Intake Form

Please Print **–**

_____ _____ _____
↑ Name **Date of Birth** **Social Security #**

_____ _____ _____ _____
↑ Mailing Address **City** **State** **Zip Code**

(_____)_____ (_____)_____ _____
↑ Home # **Cell #** **Email Address**

_____ _____ _____
↑ Emergency Contact **Contact #** **Relation**

_____
↑ To whom may we thank for referring you?

****EHR Information (DO NOT SKIP)****

Marital status:

□ Married □ Single □ Widowed □ Divorced □ Separated

Do you have any children? □ Yes □ No **Are you pregnant?** □ Yes □ No

If yes, how many? _____ **If yes,** how many weeks? _____

Do you use: □ Tobacco □ Alcohol □ Coffee

What is your current tobacco smoking status?

□ Current every day □ Current some days □ Former smoker □ Never smoker

Preferred Language:

□ English □ Spanish □ Other _____

****Health History (DO NOT SKIP)****

Medications ***Please list any medications you are currently prescribed:***

_____ _____mg _____ _____mg

_____ _____mg _____ _____mg

_____ _____mg _____ _____mg

Surgical History ***Please list ALL surgeries that you have had in the past:***

_____

_____

For office use only: height: _____ Weight: _____ Blood Pressure: _____/_____

Past Medical History **Please check box for ALL conditions that you have had prior to your current complaint:**

□ None	□ Epilepsy	□ HIV/AIDS	□ Rheumatoid arthritis
□ Arthritis	□ Gout	□ Hypertension	□ Scoliosis
□ Asthma	□ Headache	□ Jaw Pain	□ Shoulder pain
□ Blood Clots	□ Heart attack	□ Kidney disorder	□ Stroke
□ Cancer	□ Heart disease	□ Kidney stones	□ Swelling/stiffness joints
□ Cardiovascular Disease	□ Hepatitis	□ Low Back Pain	□ Thyroid disease
□ COPD	□ High Blood Pressure	□ Mid-back pain	□ Tinnitus (ear noises)
□ Depression	□ High Cholesterol	□ Neck pain	□ OTHER
□ Diabetes	□ High Triglycerides	□ Osteoarthritis	

Family Medical History **Please check box for ALL conditions that run in your family:**

□ None	□ Epilepsy	□ HIV/AIDS	□ Rheumatoid arthritis
□ Arthritis	□ Gout	□ Hypertension	□ Scoliosis
□ Asthma	□ Headache	□ Jaw Pain	□ Shoulder pain
□ Blood Clots	□ Heart attack	□ Kidney disorder	□ Stroke
□ Cancer	□ Heart disease	□ Kidney stones	□ Swelling/stiffness joints
□ Cardiovascular Disease	□ Hepatitis	□ Low Back Pain	□ Thyroid disease
□ COPD	□ High Blood Pressure	□ Mid-back pain	□ Tinnitus (ear noises)
□ Depression	□ High Cholesterol	□ Neck pain	□ OTHER
□ Diabetes	□ High Triglycerides	□ Osteoarthritis	

****Symptoms (DO NOT SKIP)****

Primary Complaint _____

Pain Scale (0 is pain free – 10 is unbearable pain) 1 2 3 4 5 6 7 8 9 10

When did it start? _____

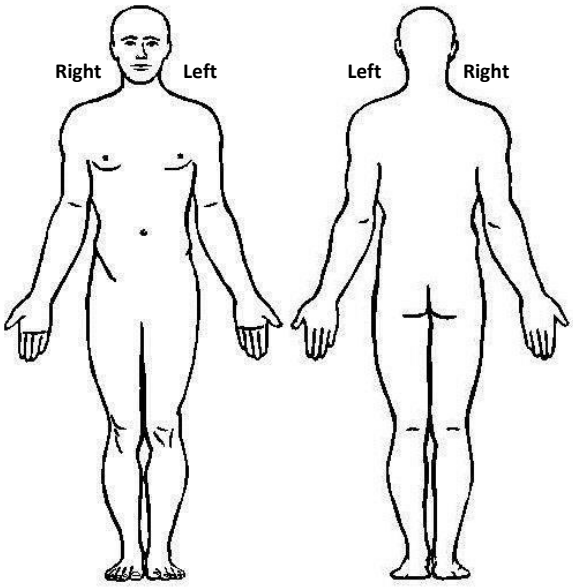
Is this related to a recent auto or work related accident? _____

The frequency of this complaint is:

□ Intermittent □ Occasional □ Frequent □ Constant

The pain/discomfort of this complaint is:

□ Dull	□ Sharp	□ Aching
□ Shooting	□ Spasm	□ Throbbing
□ Burning	□ Numbing	□ Tingling



Please mark areas of pain with an "x"

Actions effecting this complaint:

Resting	□ Aggravates	□ Relieves	**Bending forward**	□ Aggravates	□ Relieves	**Twisting left**	□ Aggravates	□ Relieves
Straining	□ Aggravates	□ Relieves	**Bending back**	□ Aggravates	□ Relieves	**Twisting right**	□ Aggravates	□ Relieves
Sitting	□ Aggravates	□ Relieves	**Bending left**	□ Aggravates	□ Relieves	**Lifting**	□ Aggravates	□ Relieves
Lying Down	□ Aggravates	□ Relieves	**Bending right**	□ Aggravates	□ Relieves	**Coughing**	□ Aggravates	□ Relieves

Other Chiropractor or Physician/Therapist? _____ If yes, When:_____

Patient Signature _____ Date _____

Doctors Notes

Love Chiropractic
Dr. Steve Love | Dr. Tiffany Love

Informed Consent for Treatment

I hereby request and consent to the performance of my chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, massage therapy, and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by Drs. Steve & Tiffany Love and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working, or associated with Love Chiropractic Center, or serving as back-up/coverage for Drs. Steve & Tiffany Love. I have had the opportunity to discuss with Drs. Steve & Tiffany Love and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand that the results are not guaranteed. I affirm that I have stated ALL my known medical conditions and have answered all questions honestly. I agree to take it upon myself to keep the doctor (s)/therapist(s) updated on my health and well-being and I understand that there shall be no liability on the practitioner's part should I fail to do so.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disk injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest. I have read, or have had read to me the above consent.

I understand that **MASSAGE THERAPISTS DO NOT** diagnose illnesses, disease or any other physical or mental disorder; nor do they prescribe medical treatment or examinations, and that it is recommended that I see a physician for these services.

I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the massage, and I will be liable for payment of the full time scheduled and I may be banned from any future massage therapy.

I have also had an opportunity to ask questions about its content, and by signing below I agree to an examination and chiropractic treatment. I intend this consent form to cover the entire course of treatment for my present condition (s) and for any future condition(s) for which I seek treatment.

I understand that I am responsible for paying the full price for massage therapy, knowing that Love Chiropractic will not bill my insurance for this service for medical treatment. I also agree that I am responsible for any missed or canceled appointments with less than 24-hr notice and that in doing so I may be charged a fee. I also understand that late arrivals may not receive their full session but will be responsible for the entire fee.

To be completed by patient or parental guardian/representative if applicable:

Patient/Responsible Party's **Signature** _____ Date _____

Love Chiropractic
Dr. Steve Love | Dr. Tiffany Love

Acknowledgment of Receipt of Notice of Privacy Practices

The patient identified below authorizes Love Chiropractic to use and/or disclose protected health information in accordance with the following specific authorizations. I understand that this form will be placed in my patient chart and maintained for six years.

1. I give Love Chiropractic permission to treat me in an open room. I am aware that other people in the office may over hear some of my protected health information, during the course of care. Should I need to speak with a doctor at any time in private, the doctor will provide a room for these conversations.

2. By signing this form, you are giving Love Chiropractic permission to use and disclose your protected health information in accordance with directives listed above.

3. I have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

***Should the patient refuse to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse treatment**. ***

I understand and may obtain a copy of the Notice *of Information Practices* from the front desk. This provides a more complete description of information uses and disclosures. I understand that I have the following right and privileges:

- The right to review the notice prior to signing this consent;
- The right to object the use of my health information for directory purpose; and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

Listed below are people to whom I authorize Love Chiropractic to release Patient Health Information

1. _____ 2. _____ 3. _____

Patient/Responsible Party's **Signature** _____

Patient/Responsible Party's **Printed Name** _____DATE_____

Love Chiropractic
Dr. Steve Love | Dr. Tiffany Love

Assignment of Benefits

I, the undersigned, hereby authorize the staff of Love Chiropractic Center to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). I authorize assignment of my insurance rights and benefits directly to this provider in order to pay for my medical bills. I also authorize the release of such information as is needed to process insurance claims by provider or agent. I understand that I am responsible for the payment of all co-pays, deductibles, and coinsurances associated with my insurance plan and in the event of non-payment by my insurance company I understand that I am responsible for all my medical bills incurred at Love Chiropractic Center. Love Chiropractic Center will not be held accountable for misinformation regarding my insurance benefits and coverage. I understand that I am responsible for all charges which may include legal fees, collection fees or other expenses incurred by the provider collecting my account.

I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

Patient/Responsible Party's **Signature**_____

Patient/Responsible Party's **Printed Name**_____

Financial Policy

The doctors and staff at Love Chiropractic Center would like to thank you for choosing our practice. We strive to provide you excellent care and our goal is to make your visits as convenient as possible.

- It is your responsibility to inform our office of any address or telephone number changes.
- Your account is to be kept current – accordingly all self-pay or insurance co-payments, co-insurances and deductibles will be collected at the time of service. Payable cash, check, Visa, MasterCard, Discover and Debit card.
- We may deny service if you are unable to provide payment(s) at time of service and your appointment may be rescheduled.
- You will only be sent a statement if your balance exceeds $5.00 and you will only receive a refund if the credit amount is over $10 and you decide not to use this as credit towards future visits. Refunds will be issued within 4-6 weeks from the date requested, if there are no pending insurance claims. For all outstanding balances, we will send ONLY TWO statements requesting your payment for the balance due.
- Collection actions will be taken on ALL accounts due over one hundred twenty (120) or more. Responsible parties who will not make an effort to seek assistance and payment plans with us may be subject to the family being dismissed from the practice.
- The first set of medical records, forms, or x-rays completed will be provided at no cost. We will charge the state mandated maximums for duplicate medical records and paperwork, as well as $15 for each additional copay of x-rays requested.

If you have health insurance coverage: We will submit your claims, however we must emphasize that as medical providers, our relationship is with you NOT your insurance company. In no circumstance will we be responsible for the accuracy of information provided to you or to us by your insurance company. Although we attempt to verify your benefits with your insurance policy, please be advised this is only an estimate of your coverage based on the information given to us at the time of the inquiry. It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your next appointment.

Patient/Responsible Party's **Signature** _____

Patient/Responsible Party's **Printed Name** _____