New Patient Intake Form

Date: _____/_____/_____ Patient SS# — XXX-XX-___ ___ ___ ___ (last 4)

Name: _____ Address:_____

Apt. #:_____ City:_____ State:_____ Zip Code:_____

E-Mail:_____ How did you hear about us? Google Yelp Friend:_____

Cell Phone:_____ Home Phone:_____ Work Phone: _____

Birth Date:_____ Age:_____ Marital: M S W D How many Children? _____

Employer:_____ Phone: _____

Emergency Contact: _____ Relationship:_____ Phone:_____

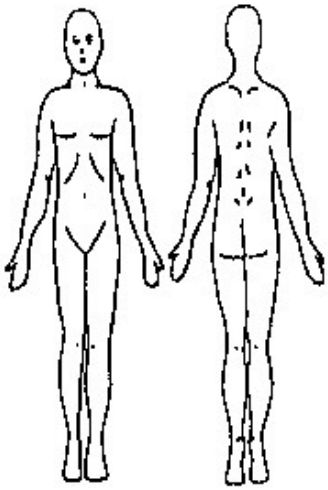
PAYMENT IS EXPECTED AT THE TIME OF VISIT! ☐ Cash ☐ Check ☐ Visa/MC

Are you insured? [ ] YES [ ] NO Insurance Company:_____

Name of current Primary Care Physician:_____

Current Medications: _____

_____



Confidential Health History

Please outline on the diagram the area of your discomfort.
Please describe your present complaints:

_____

_____

_____

_____

_____

_____

_____

NO PAIN — Please circle one of the numbers below to indicate your current level of pain. — EXTREME PAIN

1 2 3 4 5 6 7 8 9 10

Is this a work related injury? ☐ YES ☐ NO

Is this an auto related injury? ☐ YES ☐ NO

When did your present complaints occur? _____

Who has treated you for this condition (if anyone)? _____

Is this condition interfering with your ☐ Work ☐ Sleep ☐ Recreation Days missed: _____

Have you had this condition or similar conditions in the past? ☐ YES ☐ NO If so, when? _____

What treatment did you receive? _____

Name & location of previous chiropractor: _____

Approximate date of last chiropractic treatment: _____

If any of the following have happened to you, give approximate dates & briefly describe injury:

Auto accidents: _____ Motorcycle accidents: _____

Falls or other injuries: _____ Spinal or neck injuries: _____

Broken bones: _____ Knocked unconscious: _____

Surgeries: _____ Health problems of parents: _____

(Women) please give dates of childbirth _____

Please check any of the following that apply to your current/past medical history:

___ Broken / Fractured Bones	___ A Congenital Disease	___ Epilepsy
___ Circulatory Problems	___ Excessive Bleeding	___ Pace Maker
___ Rheumatoid Arthritis	___ High / Low Blood Pressure	___ Strokes
___ Seizures / Convulsions	___ Osteoarthritis	___ Ruptures
___ Cancer	___ Coughing Blood	___ Eating Disorder
___ Alcoholism	___ Drug Addiction	___ Depression
___ Gall Bladder Problems	___ Ulcers	

Do you have history of stroke or hypertension? _____

Please list any other health problems / hospitalizations you have had within the last 2 years:_____
_____

OFFICE POLICY

1. Patients are to have a scheduled appointment before being seen by a doctor. Patients may call the office **808-637-2608** and schedule an appointment. Walk-Ins will be seen but those who have an appointment will be seen with first priority.
2. Turning Point Chiropractic reserves the right to charge a missed appointment fee of **$25** for any appointment missed. It is always best to call to cancel or reschedule your appointment to avoid this fee.
3. If you have a scheduled appointment and know you will not be making it on time, please give us a call prior to your appointment so we can give other patients your time slot and so we can verify your new time is available.

The doctors of Turning Point Chiropractic do offer Emergency visits during off hours for an additional fee of **$50** for existing patients and **$100** for new patients.

4. Payment is due at the time of service. We accept cash, check, and credit card.
5. If you have insurance, please give the front desk your insurance card and ID to make a copy. We will call and verify your benefits for you. If your insurance company is closed when you come in and we're unable to verify your benefits, you will be charged full price and will be reimbursed or you can have that money applied to any deductible or co pays if you do have benefits.
6. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Turning Point Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Turning Point Chiropractic will be to my account on the receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Signature: _____ ***Date:*** _____

HIPAA CONSENT FORM

I give Turning Point Chiropractic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies and for health care operation like quality reviews.

I have been informed that I may review the clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand Turning Point Chiropractic has the right to change their privacy practices and that I may obtain any revised notices at the clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Turning Point Chiropractic is not required to agree to the request. If Turning Point Chiropractic agrees to my requested restriction, they must follow the restrictions(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for the information already used or disclosed.

Informed Consent Form

Dear Patient,
Every type of health care is associated with some risk of potential problems. This includes chiropractic health care. We wish you to be informed about the possibility of any potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Consent to Treatment

The following points have been explained to me to my satisfaction and I have had the opportunity to discuss them with the doctor and/or other clinic personnel.

1. I understand that the chiropractor will use his/her hands or a mechanical device upon my body to adjust a joint, and there may be an audible "pop" or "click" as a result of joint movement.
2. The practice of health care is not an exact science, but relies upon information related by the patient, information gathered during the examination (and the doctor's interpretation thereof), as well as the doctor's judgment and expertise. Chiropractic care is no different.
3. It is not reasonable to expect my doctor to anticipate or explain all possible risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise professional judgment during the course of any procedures that he/she feels at the time to be in my best interest.
4. Though infrequent, as with any health procedure, there are certain complications that may arise during chiropractic health care. These complications include soreness, sprains/strains, dislocations, fractures, disc injuries, cerebral-vascular accidents, physiotherapy burns, or soft tissue injuries. These complications are extremely rare occurrences.
5. Chiropractic is a system of health care delivery; therefore, as with any other health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will give you our best care.
6. I understand that there are other forms of treatment, including drugs and surgery, which could be treatment options for my condition, but at this time, I choose chiropractic care.

By signing the Confidential Patient Information intake form I acknowledge that I have read the above consent, or it has been read to me. I have had the opportunity to ask questions and receive answers; I am comfortable with the information provided and consent to chiropractic treatment and management on that basis. In signing this document, I in no way compromise my protection against negligence.

Patient Signature: _____ ***Date:*** _____