Dr. Rebecca Bomgaars, Doctor of Chiropractic

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FAMILY INTAKE

Today's Date:

1st Patient First Name: Last Name:
DOB: Height: Weight:
Gender born with: Comment:

2nd Patient First Name: Last Name:
DOB: Height: Weight:
Gender born with: Comment:

3rd Patient First Name: Last Name:
DOB: Height: Weight:
Gender born with: Comment:

4th Patient First Name: Last Name:
DOB: Height: Weight:
Gender born with: Comment:

5th Patient First Name: Last Name:
DOB: Height: Weight:
Gender born with: Comment:

6th Patient First Name: Last Name:
DOB: Height: Weight:
Gender born with: Comment:

7th Patient First Name: Last Name:
DOB: Height: Weight:
Gender born with: Comment:

8th Patient First Name: Last Name:
DOB: Height: Weight:
Gender born with: Comment:

9th Patient First Name: Last Name:
DOB: Height: Weight:
Gender born with: Comment:

Guardian's First and Last Name:

Phone #: Email address:

Preferred method of communication for patient reminders: **Email** **Phone** **Mail**

Address: City/State/Zip:

Emergency Contact:

1) Name: Phone #: Relation:
2) Name: Phone #: Relation:

Employer: Occupation:

Preferred Language:

Race: _____ American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity: _____ Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Marital status: _____ Single / Married / Divorced / Widowed

Spouse or Partner's Name: _____

Person responsible for payment: _____

How were you referred to our office? _____

INFORMED CONSENT FOR CHIROPRACTIC TREATMENTS AND CARE

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, soreness (53%), headaches (12%), tiredness (11%), radiating discomfort (10%), dizziness, bruises, fractures, disk injuries, strokes, dislocations, burns and sprains. I understand most of these possible complications will resolve within 48 hours and are part of the healing process. 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 course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest. I also understand that my condition may worsen, and referral may be necessary if a course of chiropractic care does not help or improve my condition.

Please type which member of your family has the answer yes to any of the following questions…

I am possibly pregnant.

I have been diagnosed with a heart condition.

Someone in my family died of a heart condition under the age of 30.

I have a headache or neck pain that is the worst I have ever felt.

I have become dizzy or lost consciousness when turning my head.

I have sudden weakness in my arms or legs.

I have numbness in the genital area.

I have recent inability to urinate or lack of control when urinating.

I have been diagnosed with osteoporosis.

I take corticosteroids (e.g. prednisone).

I have been diagnosed with cancer.

I have metal implants.

I take pain medications on a regular basis. How much & often?

I take blood thinners. (e.g. Warfarin, Coumadin, Heparin) How much & often?

I have had spinal surgery. When?

I have been diagnosed with any of the following: Rheumatoid arthritis, Reiter's syndrome, Cauda Equina Syndrome, Ankylosing Spondylitis, Psoriatic Arthritis, Giant Cell Arteritis (temporal arteritis), Osteogenesis Imperfecta, Ligamentous Hypermobility (such as with Marfan's Syndrome), Ehlers-Danlos syndrome, Medial Cystic Necrosis (cystic mucoid degeneration), Bechet's Disease, Fibromuscular Dysplasia, spinal stenosis, spondylolisthesis.

I have answered the above questions and read or have had read to me, the above consent, and

hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and instrument adjusting, including but not limited to: electric stimulation, ultrasound, rapid release technology, blocking, activator technique, traction, Gua Sha therapy, heat, ice, low level laser therapy, nutritional recommendations and rehabilitative procedures on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for Dr. Rebecca Bomgaars.

I have had an opportunity to discuss with Dr. Bomgaars and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures as well as any concerns I may have. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Guardian's Full Name:

Signature of Patient: **Date:**

Missed Appointment Policy

At 440 Chiropractic, your scheduled appointment time is reserved just for you. We try not to overbook appointment times in order to provide excellent care and to be sure we have sufficient time to adequately examine you and to discuss your condition and treatment options in detail with you.

We will make every effort to accommodate your scheduling needs. In return, we ask that you help us by keeping your scheduled appointments, arriving on time, and notifying us a minimum of twenty-four (24) hours in advance if you are unable to do so. When we receive advanced notice of cancellation, our day runs more efficiently and more importantly we are able to see other patients who need care. Failure to comply with this policy will necessitate the assessment of the following fees:

• 1st missed appointment - Our staff will call to ensure your wellbeing in addition to rescheduling your appointment.

• 2nd Missed Appointment - A missed appointment fee of $25 will need to be paid prior to receiving any new services. Additionally, all future exams will require pre-payment in order to secure the desired time.

Sincerely,

Dr. Rebecca Bomgaars D.C.

I understand and agree to the terms listed above.

Signed: _____ **Date:** _____

HIPAA NOTICE OF PRIVACY PRACTICES

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office.

PRACTICE'S REQUIREMENTS

The Practice:

• Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

• Is required to abide by the terms of this Privacy Notice.

• Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.

• Will distribute any revised Privacy Notice to you prior to implementation.

• Will not retaliate against you for filing a complaint.

I have read and acknowledge the Notice of Health Information Privacy Practices. I understand that I have the option to obtain copies of this notice at any time.

I, _____ authorize 440 Chiropractic to release any information pertinent to my case to business associates for purposes of carrying out billing and back-office duties.

Guardian Signature: _____ **Date:** _____

Insured Patients Instruction Sheet (Skip if Not Using Insurance)

Is this injury/illness work-related?

Have you reported it to your employer?

Employer's Address:

Is this injury/illness related to an automobile accident?

(If yes, please give following information and notify your insurance company that you are under care at this office)

Auto Insurance Co. Policy # Claim #

Agent's Name: Phone #

Address:

Name of attorney: Phone #

Do you have any type of health insurance?

Member # Policy/Group #

Insurance Company Address

Customer Service Phone # (for providers)

Insured's Name: Relation:

License #

Are you covered under any other group or individual health policy through yourself or spouse?

Insurance Company:

Address:

Policy/Group # Insured SS #

TO ALL OUR INSURED PATIENTS:

It is our policy to bill your insurance carrier(s) as a courtesy to you. However, your bill is always your responsibility because insurance is an agreement between you and your insurance carrier. The quotes they give are never a guarantee of payment. If we are out of network with your insurance, we will require the cash rate payment at the time of service. If the insurance pays us, we will reimburse you.

BALANCES UNPAID AFTER 60 DAYS WILL BE CHARGED AT A RATE OF 1.5% INTEREST PER MONTH. THE PATIENT WILL BE RESPONSIBLE FOR ANY LEGAL EXPENSES INVOLOVED IN COLLECTION OF PAST DUE ACCOUNTS.

The above is accurate to my knowledge and **I HAVE READ AND UNDERSTAND THESE INSTRUCTIONS AS THEY APPLY TO ME.**

Signature: _____ **Date:** _____

Has your family ever had Chiropractic Care before?

If YES, when and who in your family?

Is anyone in your family currently taking any medications? Please specify who.

Medication Name Dosage and Frequency (i.e. 5mg once a day, etc.) (Please include over the counter medications and who)

Any medication allergies? Who and what?

Smoking Status:
(Please specify who) Every day Smoker / Occasional Smoker / Former Smoker / Never Smoked)

alcohol intake? If yes, who, how much, what kind, and how often?

Additional comments:

For the following, if any issues below affect those included in this intake form, there is a comment box on the next page to expand.

Do you have any problems with eyes, ears, nose, and/or throat?

Any blurry vision? Corrected with glasses or contacts?

Glaucoma? Cataracts?

Headaches? How often? Where?

Ringing in the ears? How often? When did it start?

Difficulty swallowing?

Any issues with…

☐ Shoulders ☐ Hips ☐ Elbows ☐ Wrists

☐ Knees ☐ Ankles ☐ Hands ☐ Feet

☐ Digestion ☐ Bowl Function ☐ Bladder Function ☐ Night Sweats

☐ Numbness in arms or Legs, hands or feet

☐ Tingling in arms or legs, hands or feet

☐ Temperature changes in arms or legs

Notes: Please list which people in your family experience things listed above.

Any history of any accidents or surgeries? Please specify names and describe.

Mom's side family medical conditions (please specify)

Dad's side family medical conditions (please specify)

If applicable, please repeat the following two forms for each person in your family. If your child is being treated for wellness, you can skip.

What is your major complaint?

Is this condition due to auto accident, work injury, other accident, unknown cause, or illness?

Are the symptoms improving, getting worse, about the same, or intermittent (come and go)?

Date symptoms appeared:

Any activities which aggravate your condition?

(Standing / Walking / Sitting / Lying / Bending / Lifting / Twisting / Coughing)

Is there anything you cannot do that you were able to do before this issue?

Have you had these symptoms before? If so, when?

Have you seen another Doctor for this condition?

(M.D / Chiropractor / Osteopath / Acupuncture / Dentist / Podiatrist)

Doctor's Name: Date Consulted:

Diagnosis:

Treatments:

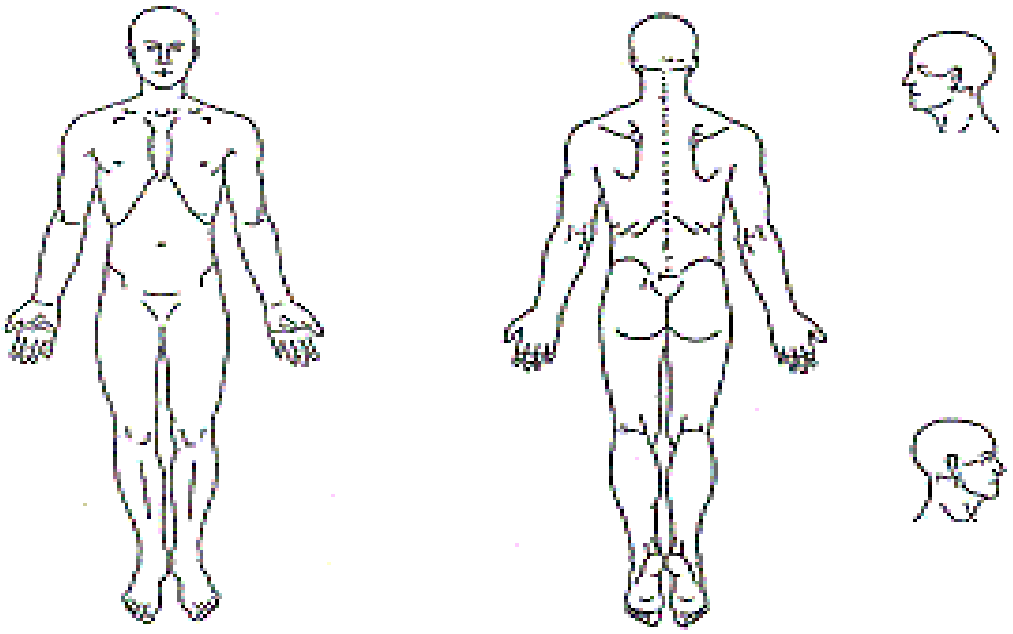
Is there anything that has helped improve your symptoms?

(e.g. Rest, Ice, Heat, lying down, sitting up, not doing a certain movement)

Do you have any limits in your range of motion in the areas of complaint?

IF YOU ARE IN PAIN, PLEASE MARK THE EXACT LOCATION OF YOUR PAIN ON THE DIAGRAM BELOW. ALSO DESCRIBE THE TYPE AND FREQUENCY OF YOUR PAIN, AS WELL AS ANY ACTIVITY WHICH BRINGS ON OR AGGRAVATES THE PAIN. FOR EXAMPLE, DULL, SHARP, CONSTANT, OFF & ON, WHEN STANDING, WHEN SITTING, ETC.

COMPLETE THESE DIAGRAMS



On a Scale of 0-10, what number would you give your pain? Please specify each area:

What is your main goal in seeking treatment?

Patient or Guardian Signature: Date:

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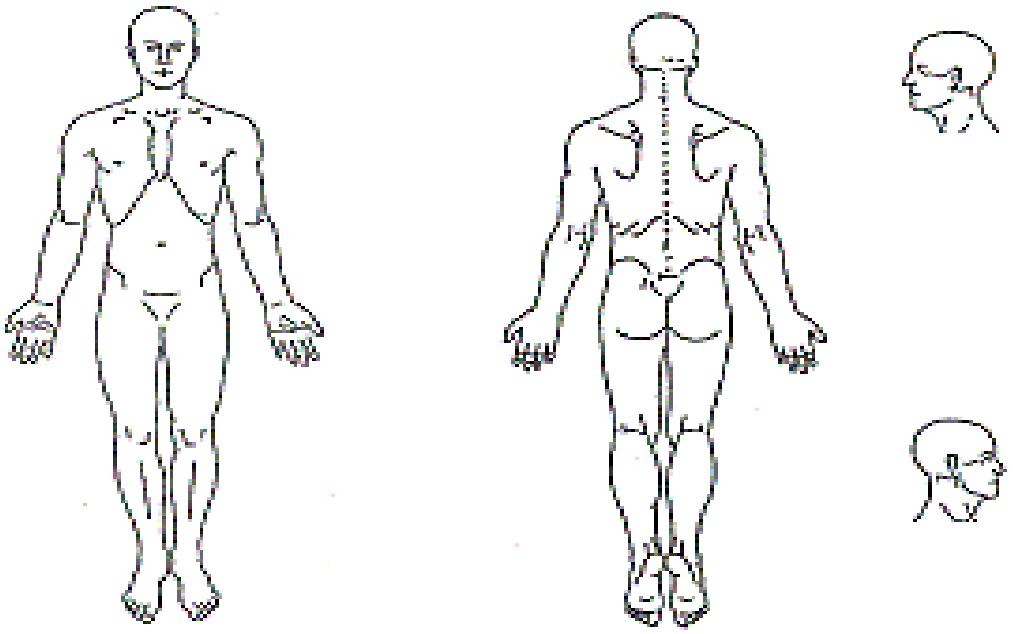

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