Patient Intake Form

Patient Information:

Full Name: _____ Date: _____
First MI Last

Address: _____ City: _____ State:_____ Zip:_____

Age:_____ Birth Date: _____ Gender: M / F

Social Security Number: _____ Email Address: _____

Cell Phone: _____ Home Phone: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

Relationship to Patient: _____

Primary Care Physician: _____ Phone Number:_____

Payment Information:

Person Responsible for Payment (if different): _____

Social Security Number: _____Phone Number: _____ Date of Birth: _____

Signed: _____ **Date:**_____

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Financial Responsibility

I have requested professional services from Diamond Sport & Spine Clinic ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____		_____
Signature	Date of Birth	Date
_____		_____

HIPAA PRIVACY
AUTHORIZATION FOR USE AND DISCLOSURE OF
PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal health care information. Please read it carefully before signing.

Diamond Sport & Spine Clinic will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that Diamond Sport & Spine Clinic may use or disclose any health care related documentation for the purpose(s) of treatment or management of the patient's health.

By signing this authorization you agree that Diamond Sport & Spine Clinic or its Business Associates may disclose your personal health care information to a requesting entity or health care provider.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Diamond Sport & Spine Clinic's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Diamond Sport & Spine Clinic has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Diamond Sport & Spine Clinic at any of its offices or by sending a written request with return address to 1426 N. Clayton St. Wilmington, DE 19806.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Diamond Sport & Spine Clinic for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Diamond Sport & Spine Clinic has taken action in reliance on it. A revocation is effective upon receipt by Diamond Sport & Spine Clinic of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Diamond Sport & Spine Clinic, or (d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA.

Diamond Sport & Spine Clinic will provide _____ [name of patient] with a copy of this signed authorization at his or her request.

Acknowledged and agreed to by:

Patient Signature: _____

Date: _____

Informed Consent for Chiropractic Treatment

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physiotherapy, physical medicine, physical therapy, etc. on me by all licensed doctors, associates, or assistants of Diamond Sport & Spine Clinic.

I understand, as with any health care procedure, there are certain complications which may arise during or after treatment. Those complications include but are not limited to: fractures, disc injuries, dislocations, sprain/strain injuries, soreness, and costovertebral strains and separations. Some types of neck manipulations have been associated with injuries to the arteries of the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely upon the doctor to exercise judgment during the course of the care which the doctor feels at the time, based upon the facts then known that are in my best interest.

I have had an opportunity to discuss the nature, purpose, and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatment. I state that I have been informed and weighed the risks and benefits involved with chiropractic care at this office. I have decided that it is in my best interest to receive treatment at Diamond Sport and Spine Clinic. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s), and for any future condition(s) for which I seek treatment.

Patient/Representative Signature: _____

Date:

_____

Initial Health Status

First Name _____ Middle Initial _____ Last Name _____

Patient Smoking Status _____ Patient Smoking Frequency _____

Referring Physician (if applicable)

_____

Is this?

- ○ Work Related
- ○ Auto Related
- ○ N/A

Describe your current problem and how it began: _____ How long have you experienced these symptoms? _____

Surgery date, if applicable

_____

Please describe where on your body you have pain or other symptoms:

_____

How often are your symptoms present?

- ○ Constantly (76-100% of the day)
- ○ Occasionally (26-50% of the day)
- ○ Frequently (51-75% of the day)
- ○ Intermittently (0-25% of the day)

Check all that apply to your pain:

- ☐ Sharp
- ☐ Dull Ache
- ☐ Numb
- ☐ Shooting
- ☐ Burning
- ☐ Tingling

How is your condition changing?

- ○ Getting Better
- ○ Not Changing
- ○ Getting Worse

Briefly explain what makes your problem:

Less Severe _____ More Severe _____

Current complaint (how you feel today):

○ 0 = No Pain ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 = Unbearable Pain

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?

○ 0 = No Pain ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 = Unbearable Pain

In general would you say your overall health right now is:

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor

Have you had x-rays, MRI, CT Scan for your area(s) of complaint?

- ○ Yes
- ○ No

What areas were taken? _____

Date(s) taken _____

What facility/Location _____

_____

Please check all of the following that apply to you:

- ☐ Abnormal Weight Gain/Loss
- ☐ Alcohol/Drug Dependence
- ☐ Blurred Vision
- ☐ Cancer/Tumor (Explain Below)
- ☐ Cardiac Condition
- ☐ Constipation
- ☐ Current Medications
- ☐ Currently Pregnant, (Enter # Weeks Below)
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Headaches
- ☐ Heart Palpitations
- ☐ High Blood Pressure
- ☐ Indigestion
- ☐ Night Sweats
- ☐ Numbness (Enter Location Below)
- ☐ Osteoporosis
- ☐ Pain at Night
- ☐ Pain Unrelieved by Position or Rest
- ☐ Recent Fever
- ☐ Seizures
- ☐ Stroke (Enter Date Below)
- ☐ Surgeries
- ☐ Tobacco Use
- ☐ Tremors
- ☐ Unusual Bleeding
- ☐ Urinary Problems
- ☐ Other Health Problems (Explain Below)
- ☐ Ankle Pain
- ☐ Elbow Pain
- ☐ Finger Pain
- ☐ Foot Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Leg Pain
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Pain Between Shoulder Blades
- ☐ Shoulder Pain
- ☐ Toe Pain
- ☐ Wrist Pain

Cancer/Tumor (Explain) _____

Numbness (Location) _____

Currently Pregnant, # Weeks _____

Stroke Date: _____

Other Health Problems _____

List any surgeries you have had, with the month/year _____

List any hospitalizations, with month/year _____

Current Medications (Please include vitamins and supplements) _____

Allergies _____

Who have you seen for your condition before today?

- [ ] No One
- [ ] Medical Doctor
- [ ] Massage Therapist
- [ ] Chiropractor
- [ ] Physical Therapist Acupuncturist
- [ ] Occupational Therapist
- [ ] Speech Therapist
- [ ] Athletic Trainer
- [ ] Other

Other:

_____

What treatment did you receive and when?

_____

Your concerns and goals are very important to the outcome of your treatments. Please indicate any other pertinent information concerning you and / or your health which was not addressed within this form

_____

I certify to the best of my knowledge, the above information is complete and accurate. I understand that this provider/practitioner may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to this provider/practitioner to contact my physician, if necessary.

Patient/Responsible Party Signature:

Date

_____