PATIENT WELCOME PACKET

Date: _____/_____/_____

First Name:_____ **Last Name**:_____

Electronic Health Records Intake Form

In compliance with Medicare requirements for the government EHR incentive program

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

DOB: ___/___/____ Gender: ❑Male ❑Female **Preferred Language:_____**

Smoking Status: ❑Every Day Smoker ❑Occasional Smoker ❑Former Smoker ❑Never Smoked

CMS requires providers to report both race and ethnicity

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

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Prescribing Doc / Why	Dosage/Frequency (ex 5mg once a day)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

❑ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature (X): _____ Date:____/____/_____
***For your protection,** Your name and date are necessary on each page of this packet

For office use only

Height: _____ Weight:_____ Blood Pressure:_____ /_____

PATIENT WELCOME PACKET

Date: _____/_____/_____

Patient Information

Name: _____
Last First MI

Email address: _____

Mailing Address: _____

_____

Phone # H (_____)_____-_____ W (_____)_____-_____ Other (_____)_____-_____

Date of Birth: ____/____/_____ Sex: ❑ Male ❑ Female SS#: _____/_____/_____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

How did you hear about our practice? _____

Primary Physician: _____ Type of Physician: _____

Physician Address: _____ Phone: (_____)_____-_____

Emergency contact: Name: _____ Relation: _____

Phone #: H(_____)_____-_____ W(_____)_____-_____ Other(_____)_____-_____

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other _____

Has it been reported? ❑ Yes ❑ No If yes, to whom? _____

Financial Information

Name of person responsible for this account: _____

If other than Self: Relationship to person: _____ Phone: (_____)_____-_____

Policy Holder's Date of Birth: ____/____/_____ Policy Holder's SS#: _____/_____/_____

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release: (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, CORE Health Centers, LLC., INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Patient Signature (X) _____ Date ____/____/_____

PATIENT WELCOME PACKET

Health Questionnaire

I consent to receiving a health screening. I realize that I am not receiving a diagnosis, treatment or prognosis for any condition that I may be experiencing. I acknowledge that I am receiving a screening only and agree to hold harmless the physicians and/or clinic from any damage resulting from this screening.

_____ _____ ____/____/_____

Patient Printed Name **Signature of Patient/Guardian** **Date**

Physical Stress History

Age:_____ Occupation: _____ # Hours/Week Working:_____

Primary Duties: _____ How long you worked this Job:_____

Check off any of the following symptoms you have experienced IN THE PAST 6 MONTHS:

- ❑ Low Back Pain
- ❑ Pain between Shoulder Blades
- ❑ Neck Pain
- ❑ Tension/Headaches
- ❑ Fibromyalgia
- ❑ Decreased Libido
- ❑ Tension Across Top of Shoulders
- ❑ Numbness/Tingling in Arms/Hands
- ❑ Numbness/Tingling in Legs/Feet
- ❑ Pain in the legs
- ❑ Pain in the feet
- ❑ Weight Gain
- ❑ Tired/Fatigued
- ❑ Difficulty Sleeping
- ❑ Allergies
- ❑ Digestive Problems
- ❑ Carpal Tunnel
- ❑ Decreased Concentration

OTHER (explain) _____

Which of the above is the worst? _____

How long have you had it? _____

How often does it occur? _____

What does it feel like ?(describe) _____

How bad is it, when it is at its worse? (Scale 0-10, 10 being the worst pain you have ever felt.) _____

What activities would you like to do if this was not a problem? _____

Does this cause you to be:

- ❑ Moody
- ❑ Irritable
- ❑ Restless sleeping
- ❑ Impatient with others

Does this affect your work by:

- ❑ Worsening your decision making
- ❑ Restricting your daily activities
- ❑ Exhausting you by the end of the day
- ❑ Decreasing productivity
- ❑ Making you unable to work long hours

Does this affect your life by:

- ❑ Causing you to lose patience with your spouse/children
- ❑ Restricting household duties
- ❑ Hindering ability to exercise or play sports
- ❑ Interfering with hobbies or other activities

What have you tried to do to help relieve/get rid of this problem, and how much did it help?

❑ **Medical Doctor**	Helped: ❑ Little ❑ Some ❑ Much	Type of Tx: _____	Duration: _____
❑ **Chiropractic**	Helped: ❑ Little ❑ Some ❑ Much	Type of Tx: _____	Duration: _____
❑ **Medications**	Helped: ❑ Little ❑ Some ❑ Much	Type of Tx: _____	Duration: _____
❑ **Physical Therapy**	Helped: ❑ Little ❑ Some ❑ Much	Type of Tx: _____	Duration: _____
❑ **Exercise**	Helped: ❑ Little ❑ Some ❑ Much	Type of Tx: _____	Duration: _____
❑ **Nutrition**	Helped: ❑ Little ❑ Some ❑ Much	Type of Tx: _____	Duration: _____
❑ **Stretching**	Helped: ❑ Little ❑ Some ❑ Much	Type of Tx: _____	Duration: _____

OTHER _____

PATIENT WELCOME PACKET

Health History

Please check to indicate if you are CURRENTLY experiencing any of the following conditions:

❑ Neck Pain/Stiffness	❑ Pins/Needles in Arms	❑ Light Bothers Eyes	❑ Sudden Weight Loss	❑ Nausea
❑ Back Pain/Stiffness	❑ Pins/Needles in Legs	❑ Depression	❑ Loss of Taste	❑ Cold Feet
❑ Arm/Hand Pain	❑ Fatigue	❑ Nervousness	❑ Loss of Memory	❑ Chest Pain
❑ Leg/Knee Pain	❑ Sleeping Difficulties	❑ Tension	❑ Jaw Problems	❑ Fever
❑ Headaches	❑ Loss of Smell	❑ Cold Sweats	❑ Constipation	❑ Fainting
❑ Dizziness	❑ Allergies	❑ Stomach Problems	❑ Shortness of Breath	❑ High Blood Pres.
❑ Asthma	❑ Blurred Vision	❑ Night Pain	❑ Bowel/Bladder Changes	❑Dec. Mood
❑ Weight Gain	❑ Decreased Concentration	❑ Decreased Libido	❑ Decreased Muscle mass	❑Impotence

Please check to indicate if you have EVER HAD ANY of the following:

❑ Aids/HIV	❑ Cancer	❑ Hepatitis	❑ Osteoporosis	❑ Stroke
❑ Alcoholism	❑ Cataracts	❑ Hernia	❑ **Pacemaker**	❑ Suicide Attempt
❑ Allergy Shots	❑ Chemical Dependency	❑ Herniated Disc	❑ Parkinson's Disease	❑ Thyroid Problems
❑ Anemia	❑ Chicken Pox	❑ Herpes	❑ Phlebitis	❑ Tonsillitis
❑ Anorexia	❑ **Diabetes**	❑ High Cholesterol	❑ Pinched Nerve	❑ Tuberculosis
❑ Appendicitis	❑ Emphysema	❑ High Blood Press.	❑ Pneumonia	❑ Tumors/Growths
❑ Arthritis	❑ Epilepsy	❑ Kidney Disease	❑ Polio	❑ Typhoid Fever
❑ Asthma	❑ Fractures	❑ Liver Disease	❑ Prostate Problems	❑ Ulcers
❑ Bleeding Disorders	❑ Glaucoma	❑ Measles	❑ Prosthesis	❑ Vaginal Infxns
❑ Breast Lump	❑ Goiter	❑ Migraines	❑ Psychiatric Care	❑ Varicose Veins
❑ Bronchitis	❑ Gonorrhea	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Venereal Disease
❑ Bruise Easily	❑ Gout	❑ Mononucleosis	❑ Rheumatic Fever	❑ Whooping Cough
❑ Bulimia	❑ Heart Disease	❑ Multiple Sclerosis	❑ Scarlet Fever	❑ Other _____
❑ Hypertension	❑ Hematomas	❑ Mumps	❑ Skin Condition	❑ Other _____

1. Are you currently under drug and/or medical care? ❑ Yes ❑ No If Yes, explain _____
2. Are you Diabetic? ❑ Yes ❑ No if Yes, please answer "i":
   i. How Long:_____ Insulin Dependent? ❑ Yes ❑ No Diagnosed with Neuropathy? ❑ Yes ❑ No
3. Please list any surgeries and/or hospitalizations you have had (type & date): _____
4. Please list any allergies: _____
5. Please list any supplements you are currently taking (vitamins/herbs/minerals): _____
6. Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings) ❑ Heart Disease_____ ❑ Diabetes _____
   ❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____
7. Do you exercise: ❑ Frequently ❑ Moderately ❑ Occasionally ❑ None
8. Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor
9. Do you sleep on your: ❑ Back ❑ Side ❑ Stomach Do you use a cervical pillow? ❑ Yes ❑ No
10. What is your intake of: Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____packs/day
11. Have you consumed any alcohol in the last 24 hours? ❑ Yes ❑No
12. Do you wear ❑contacts or ❑eye glasses?
13. (Females) # of Pregnancies:____ Irregular Periods: ❑ Yes ❑No Severe Cramps: ❑ Yes ❑No Excessive Flow: ❑ Yes ❑No

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

_____ _____ ____/____/_____

Patient's Printed Name **Signature of Patient/Guardian** **Date**

PATIENT WELCOME PACKET

Consent to Care

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis; including, but not limited to: all tests, exams, therapies, durable medical equipment, injections, and other medical treatment. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury.

The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. I realize the practice of medicine is not an exact science and no person has made guarantee about the outcome of my care. It is my responsibility, as the patient, to make it known whatever I am suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the foregoing.

_____	_____	____/____/_____
Patient Printed Name	**Signature of Patient/Guardian**	**Date**

X-ray Questionnaire: For WOMEN ONLY

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary, we would like to confirm that you are not pregnant at this time.

- ❑ There is a possibility that I a may be pregnant at this time.
- ❑ Yes, I am definitely pregnant
- ❑ No, I am definitely not pregnant at this time

❑ I request that x-ray films not be taken because: _____
_____
_____

Date of last menstrual period: ____/____/_____

_____	_____	____/____/_____
Patient's Printed Name	**Signature of Patient/Guardian**	**Date**

Patient Missed Appointment Policy

It is our wish that each and every one of our patients receive the very best care and service possible. **Your Treatment Program** consists of a specific series of treatment given over a pre-planned time span. If you do not follow this plan, then you will not receive your desired results.

If we did not insist that you meet all your appointments, we would be doing you a disservice and it would indicate that we did not care. We do not want to do you a disservice, and we do care about you and the success of your program here. Therefore, we have a few simple agreements that we insist you honor:

1. Meet all your appointments and attend your included mandatory workshop. Arrange the activities in your life so that this can occur.

2. If you become ill, we still want you to come in, because **Treatments** will help you recover.

3. If you are unable to make it in due to an emergency, please call us and let us know so we can reschedule your appointment.

4. With the exceptions of unexpected emergencies, we require that you notify us at least 24 hours in advance as to any appointment changes.

5. **All cancelled or missed appointments must be rescheduled and made up that week if a day is available, if not, then it must be made up the following week.**

6. We are here for you to get the results you want, so expect us to call and remind you of your appointments, especially if it is past your scheduled appointment time.

I have read, understand, and agree to follow my Treatment Plan-of-Care:

_____ _____ ____/____/_____

Patient's Printed Name **Signature of Patient/Guardian** **Date**

PATIENT WELCOME PACKET

Financial Office Policies

1. All patients are on a cash basis until our staff can verify all insurance coverage(s).
2. Your insurance will be verified promptly and will be reviewed with you if applicable.
3. After coverage and deductible are verified, this office may accept assignment on most policies provided the insured/patient signs an appropriate statement of benefits and/or a lien authorizing payment to be sent to the doctor.
4. Waiting for the insurance payment is a courtesy and it may be withdrawn under certain circumstances.
5. As a patient, it is your responsibility to take care of the co-payment (usually a percent or fixed dollar amount) and any non-covered services on a monthly basis. This office may make payment arrangements on an individual basis. Any such plan or arrangements will be discussed during your report of findings.
6. This office does not warrant or guarantee that your insurance company will pay, nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between the insurance carrier and the patient/insured.
7. Any service not covered or coverage reductions by your insurance carrier will be the patient's responsibility.
8. This office will submit an insurance claim for you. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly with your insurance adjuster or agent. Any denied or disputed claims will be treated as uncovered.
9. If your account should go to collections for any reason, it will be the patient's responsibility for any court costs, attorney's fees, and or collection costs incurred in collecting the account balance.
10. I authorize the release of any medical or other records or information from my health record. I authorize release of records or information necessary to process any claims.
11. If you receive correspondence of checks from your insurance company, you agree to bring these into our department so that we may determine if any action needs to be taken or if the check is on assignment to this office.
12. If you change insurance companies or employers, you agree to provide this office with the current information immediately.
13. This office accepts MasterCard, Visa, American Express, Discover Card, personal checks and cash.
14. If you have any questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the doctor.
15. If you stop care and have a financial agreement signed with our office, you will be responsible for any/all charges that you have incurred at our office.

Thank you for your cooperation in this matter.
I have read and fully understand the financial office policy and agree to abide by these terms.

_____ _____ ____/____/_____

Patient's Printed Name **Signature of Patient/Guardian** **Date**

PATIENT WELCOME PACKET

Non-Assignment of Insurance Benefits Policy

If my insurance company will not assign benefits over to C.O.R.E Health Centers, meaning that any amount due to C.O.R.E Health Centers would be mailed to me, the patient, and not to C.O.R.E Health Centers, I agree to follow the below ***Non- Assignment of Insurance Benefits policy***:

I ,_____, agree that if C.O.R.E Health Centers treats me, I will be responsible to pay my deductible, co-payments or co-insurance that is due for each of my allowed visits. My insurance company and I will determine what is allowed per our own policy agreements. As the insurance disburses funds to me, the patient, I am required to bring the payments to C.O.R.E Health Centers within seven (7) days. To assist me in making my payments and staying in good standing, my insurance company makes it common practice to send all health care providers, including C.O.R.E Health Centers, a copy of all payments, or an *Explanation of Benefits* (EOB), that I will receive, minus any payments I have already made.

If I, the patient, do not pay C.O.R.E Health Centers for services rendered within seven (7) days of receiving such payments, C.O.R.E Health Centers may charge that amount that I received from my insurance company on a credit card that I have given them to keep on file. C.O.R.E Health Centers will only charge the credit card if payment is not brought in within seven (7) days of my receiving reimbursement from my insurance company. If unusual circumstances arise, where I cannot bring the payment in, I will call C.O.R.E Health Centers to let them know, so that my credit card will not be charged and I will stay in good standing. (Ex. I'm out of town, emergency, etc.)

If the insurance company denies my claim, I will be responsible for all services rendered.

I have read the above policy and my signature below indicates that I understand and agree to follow this policy.

_____ _____ ____/____/_____

Patient's Printed Name **Signature of Patient/Guardian** **Date**

Patient Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have reviewed the ***Notice of Privacy Practices*** of C.O.R.E Health Centers.

Please initial one of the following:

_____ I do not request a copy of the ***Notice of Privacy Practices*** at this time. I acknowledge that I can request a copy at any time, and that the ***Notice of Privacy Practices*** is posted at the front desk for me.

_____ I wish to receive a paper copy of the ***Notice of Privacy Practices***.

_____ I wish to receive an electronic copy of the ***Notice of Privacy Practices***.

Please read and initial ALL below:

_____ I acknowledge that it is the policy of CORE Health Centers to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the CORE Health Centers Compliance Officer about my concerns.

_____ _____ ____/____/_____

Patient's Printed Name **Signature of Patient/Guardian** **Date**