Patient Intake
Please Complete All Fields

Date: _____ **Patient # _____**

Name: (Mr. Mrs. Ms. Dr.) _____

Address: _____City _____State _____Zip_____

Home Phone (_____)_____Cell(_____)_____Fax(_____)_____

Date of Birth_____/_____/_____ Age_____ Social Security #_____-_____-_____

Marital Status: M S D W Number of Children:_____ Email Address_____

Occupation: _____ Employer_____

Employer's Address: _____Phone #:(_____)_____

Spouse Name: _____ Social Security #_____-_____-_____

Spouse's Date of Birth:_____

Occupation: _____Employer_____

Employer's Address_____ Phone #:(_____)_____

Emergency Contact: _____ Phone #:(_____)_____

How did you hear about our office? _____

Please check any and all insurance that may be applicable in this case.

__Major Medical __Medicare __Secondary __Medicaid __ Auto Accident __ Other

Name of Primary Insurance Company_____

Address_____ Phone #:(_____)_____

ID#: _____ Group #: _____

Name of Secondary Insurance Company (if any)_____

Address_____ Phone #:(_____)_____

ID#: _____ Group #:_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts.

Affidavit Signature:_____Date:_____

Primary Care Physician Name :_____ Phone:(_____)_____

Date of Last Physical _____

May Rodgers Stein Chiropractic Center contact your Primary Care Physician on your behalf if necessary?_____

Please describe the purpose of this appointment _____

Number of doctors seen for this condition 1 2 3 4 5 6 7 8 9 10

What is your major symptom? _____

Name_____(Cont'd)

What does this prevent you from doing or enjoying?_____

If this is a recurrence, when was the first time you noticed this problem?_____

How did it originally occur?_____

Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____

If yes, when and how? _____

How frequent is the condition? Constant _____ Daily _____ Intermittent _____ Night Only ___ Other___ please describe_____

How long does it last? All Day _____ Few Hours _____ Minutes _____

Have you had X-rays taken? (Circle) low back_date___/___/_____ neck_date___/___/_____chest_date ___/___/_____

Other_____ Date ___/___/_____

Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____

Burning _____ Stabbing _____ Other _____

What makes the problem worse? Standing ____ Sitting _____ Lying _____ Bending _____

Lifting _____ Twisting _____ Other _____

Please rate your pain using the following scale: (0=no pain, 10 = worst possible pain):

Current pain intensity:	1__	2__	3__	4__	5__	6__	7__	8__	9__	10__
Average pain intensity:	1__	2__	3__	4__	5__	6__	7__	8__	9__	10__
Worst pain intensity:	1__	2__	3__	4__	5__	6__	7__	8__	9__	10__

<u>Education level</u>

□ Grade 8 or less
□ Partial high school
□ High school graduate
□ Some college
□ College graduate
□ Masters or Higher

<u>Employment Status</u>

□ Paid full time
□ Paid part time
□ Homemaker
□ Student
□ Unemployed
□ Retired
□ Other

<u>Main Work Activity</u>

□ Heavy labor
□ Light labor
□ Mostly sitting at desk
□ Mostly standing
□ Mostly walking/moving about
□ Driving or operating vehicle

<u>Job Satisfaction</u>

□ Really like my job
□ Like my job
□ No opinion
□ Dislike my job
□ Really dislike my job

Do you smoke?_____ If yes, how many packs per day._____

Do you drink alcohol? _____ If yes, amount _____

Do you drink caffeine? _____ If yes, amount _____

Name:_____(Cont'd)

PATIENT HISTORY

PERSONAL HISTORY

Childhood Diseases: Measles_____ Mumps_____ Chicken Pox_____ Others_____

Unusual Childhood Diseases:_____

Adult Illnesses or Conditions: _____

Surgeries/Hospitalizations:_____

Fractures:_____

Please list all Medications/ Supplements that you are currently using and the reason(s) you are using them:

_____

_____

_____

Are you allergic to any drugs or medications?_____

Do you have allergies to any of the following? Food____ Airborne ____ Lotions/oils/perfumes ____ Seasonal ____

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? Please indicate with the letter N if you have these conditions now or P if you have had these conditions previously.

N = Now P = Previously

Headaches_____ Frequency	_____	Loss of Balance	_____
Neck Pain	_____	Fainting	_____
Stiff Neck	_____	Loss of Smell	_____
Sleeping Problems	_____	Loss of Taste	_____
Back Pain	_____	Unusual Bowel Patterns	_____
Nervousness	_____	Feet Cold	_____
Tension	_____	Hands Cold	_____
Irritability	_____	Arthritis	_____
Chest Pains/Tightness	_____	Muscle Spasms	_____
Dizziness	_____	Frequent Colds	_____
Shoulder/Neck/Arm Pain	_____	Fever	_____
Numbness in Fingers	_____	Sinus Problems	_____
Numbness in Toes	_____	Diabetes	_____
High Blood Pressure	_____	Indigestion Problems	_____
Difficulty Urinating	_____	Joint Pain/Swelling	_____
Weakness in Extremities	_____	Menstrual Difficulties	_____
Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing in Ears	_____
Heart Attack/Stroke	_____	Thyroid problems	_____
Sexually transmitted disease	_____	Heart murmur	_____
Heart valve problems	_____		

Name:_____(Cont'd)

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age[ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Stroke						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

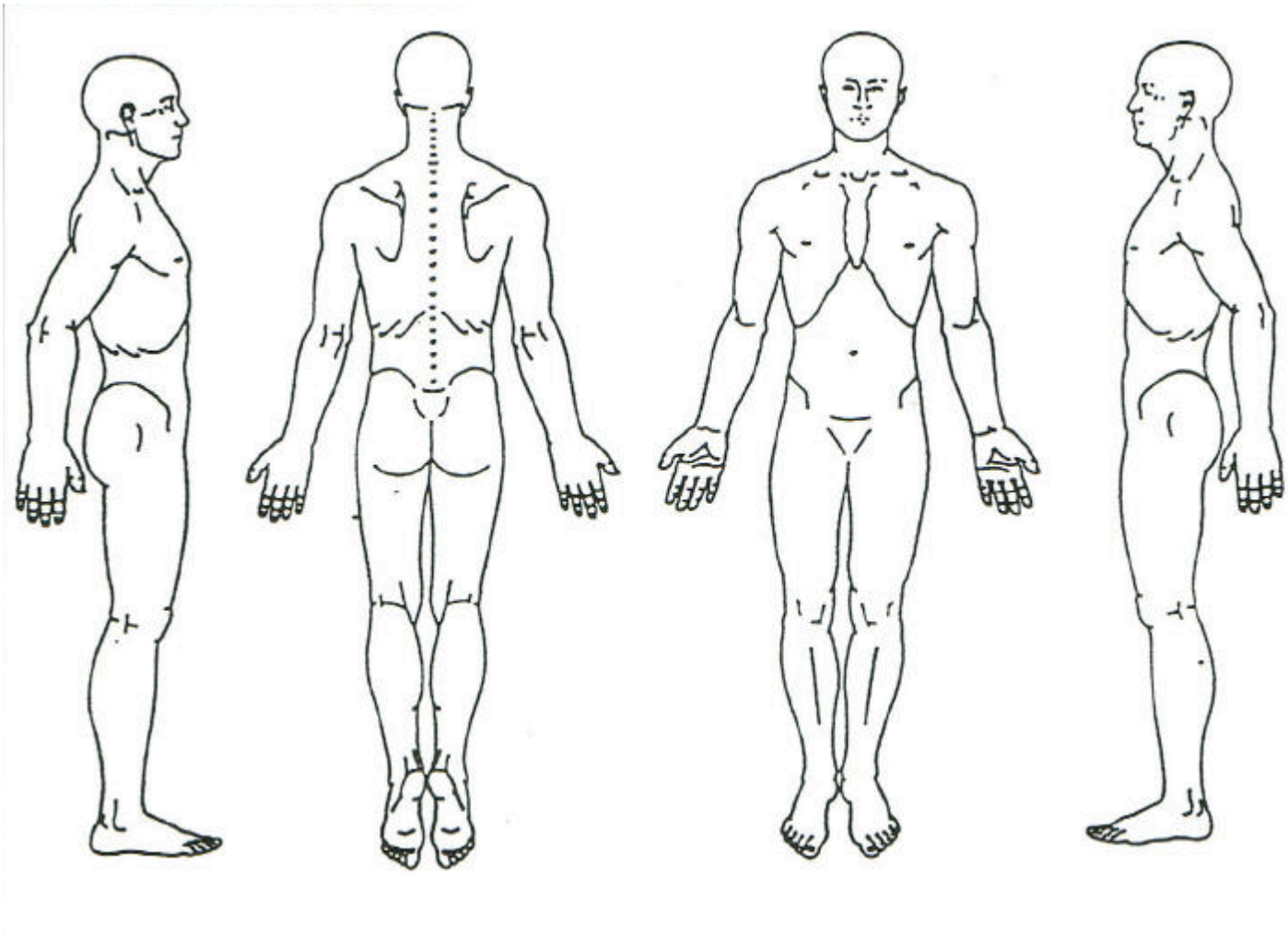
_____

_____

Name: _____(Cont'd)

Please use the following key to accurately mark the areas in which you feel the described sensations. Include all affected areas. .

Dull Ache NNN **Stabbing/Cutting //////** **Burning XXX** **Pinching PPPP**
Cramping SSSSS **Numbness -- -- -- -- --** **Tingling (pins & needles) OOOO**



Using the scale 0-100, with 0= no pain and 100 = worst possible pain, please write the number indicating your pain level _____.

Affidavit Signature:_____ Date:_____

Rodgers Stein Chiropractic Center
Dr. Stacey L. Rodgers D.C.
3303 West Davis Street
Conroe, TX 77304
936-441-9990

INFORMED CONSENT TO 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, physio therapy, physical medicine, physical therapy procedures, etc.on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in 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 procedure(s) 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 with the doctor(s) named above and/or with office personnel 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.

I have read (or have had read to me) the above explanation of the chiropractic treatments.

By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. 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 conditions(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

_____
Printed name of Patient

x_____ _____
Signature of Patient Date

x_____ _____
Signature of Representative (if patient is minor or handicapped) Date

x_____ _____
Witness to Patients' Signature Date

Doctor:_____

Rodgers Stein Chiropractic
Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

By_____
Patient's Signature

Date_____
(Month/Day/Year)

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

Rodgers Stein Chiropractic
3303 West Davis Street
Conroe, Texas 77304
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I understand all X-rays or other imaging studies are the property of Rodgers Stein Chiropractic Center. Copies of medical records are available, and there is a charge for copies of any paper records or imaging studies.

*I have read and understand the payment policy of Rodgers Stein Chiropractic Center. I understand that my insurance is an arrangement between myself and my insurance company, **NOT** between Rodgers Stein Chiropractic Center and my insurance company. I request that Rodgers Stein Chiropractic Center prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at Rodgers Stein Chiropractic Center fees will be due and payable immediately.*

_____

Patient's signature (or guardian if patient is a minor) Date

_____

Witness

SPECIAL PAYMENT INSTRUCTIONS

Patient's Name:_____

Insurance Deductible:_____

Deductible as yet unsatisfied:_____

Copay/Co-Insurance:_____

Copay on Exams:_____

Rodgers Stein Chiropractic Center

FINANCIAL POLICY

Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE
We request that 100% of the visit be paid at the time of the service. We accept your check, Master Card, Visa, Discover, or American Express.

GROUP OR INDIVIDUAL INSURANCE
When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company **are not** a guarantee of payment. Payment will be due by you at the time of service for any non-covered services, deductibles or co-pays.

ANNUAL FEE
There is an Annual Fee of $50.00 per patient or $100.00 per family collected on the first visit of each year.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS
We accept PI insurance cases on a case by case basis. We must have verification from your insurance carrier and a signed assignment of benefits on file prior to treatment. Notify our office immediately if an attorney is representing you. Once the claim is settled or if you suspend or terminate care prior to release by Rodgers Stein Chiropractic Center, any fees for services are due immediately. We also require you to sign a credit card guarantee for any unpaid balances remaining after six months.

MEDICARE
We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay deductible and the remaining 20% as well as any non-covered services. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE
Please inform us of any secondary insurance you may have.

Flex Plans/Medical Savings Accounts

Please inform us if you have a medical savings account, sometimes known as a 'Flex Plan'. We will be happy to provide you with a statement of your charges for reimbursement.

DESIGNATION OF AUTHORIZED REPRESENTATIVE

I, _____, do here by designate Stacey Rodgers, D.C. and/or Rodgers Stein Chiropractic Center (hereafter referred to as "my doctor", to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan with respect to any medical or other healthcare expense(s) incurred as a result of the services I receive from the above named doctor. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain record, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies, all in connection with medical or other health care expense(s) as the result of the services I received from my doctor.

_____ _____
Patient's Signature Date

_____
Printed Name

_____ _____
Witness Date