

Rodgers Stein Chiropractic Center

New Patient Intake Please Complete All Fields

Date: _____

Patient # _____

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

Address: _____ City _____ State _____ Zip _____

Date of Birth _____ / _____ / _____ Age _____ Social Security # _____ - _____ - _____

Home Phone (_____) _____ Cell(_____) _____ Fax(_____) _____

Email Address _____

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

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: _____

Doctor: _____

Rodgers Stein Chiropractic Center

Name: _____ (Cont'd)

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? _____

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__

Education level

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

Employment Status

- ☐ Paid full time
- ☐ Paid part time
- ☐ Homemaker
- ☐ Student
- ☐ Unemployed
- ☐ Retired
- ☐ Other

Main Work Activity

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

Job Satisfaction

- ☐ 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 _____

Doctor: _____

Rodgers Stein Chiropractic Center

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 _____
Neck Pain _____
Stiff Neck _____
Sleeping Problems _____
Back Pain _____
Nervousness _____
Tension _____
Irritability _____
Chest Pains/Tightness _____
Dizziness _____
Shoulder/Neck/Arm Pain _____
Numbness in Fingers _____
Numbness in Toes _____
High Blood Pressure _____
Difficulty Urinating _____
Weakness in Extremities _____
Breathing Problems _____
Fatigue _____
Lights Bother Eyes _____
Ears Ring _____
Heart Attack/Stroke _____
Sexually transmitted disease _____
Heart valve problems _____

Loss of Balance _____
Fainting _____
Loss of Smell _____
Loss of Taste _____
Unusual Bowel Patterns _____
Feet Cold _____
Hands Cold _____
Arthritis _____
Muscle Spasms _____
Frequent Colds _____
Fever _____
Sinus Problems _____
Diabetes _____
Indigestion Problems _____
Joint Pain/Swelling _____
Menstrual Difficulties _____
Weight Loss/Gain _____
Depression _____
Loss of Memory _____
Buzzing in Ears _____
Thyroid problems _____
Heart murmur _____

Doctor: _____

Rodgers Stein Chiropractic Center

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:

Doctor: _____

Rodgers Stein Chiropractic Center

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 /////

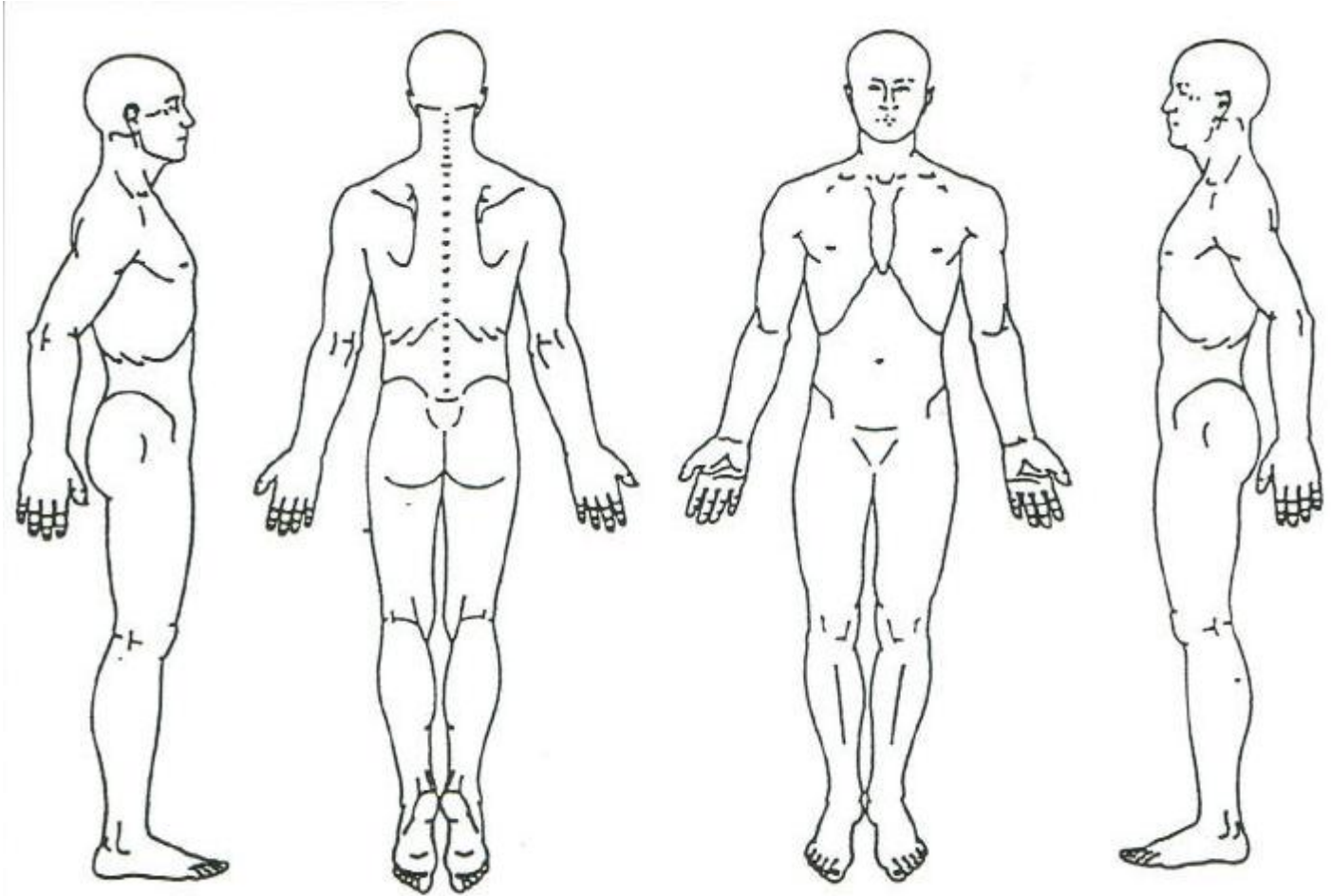
Burning XXX

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: _____

Doctor: _____

Rodgers Stein Chiropractic Center

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, Horner's 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 Center

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

Name _____
Print Patient's Name

Date _____

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

Rodgers Stein Chiropractic Center
3303 West Davis Street
Conroe, TX 77304
(936) 441-9991

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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.

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 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

Rodgers Stein Chiropractic Center

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 \$75.00 per patient or \$150.00 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.

FSA/HSA

Please inform us if you have a medical savings account, sometimes known as a 'Flex Plan'. FSA's and HSA's allow you to pay for your medical care with tax-free money. Whenever needed you can request an itemized statement with payment and services received 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 (or guardian if patient is a minor)

Date

Printed Name

Witness

Rodgers Stein Chiropractic Center

CONSENT TO RECEIVE ELECTRONIC COMMUNICATIONS

Your consent to receive electronic communications includes, but is not limited to:

- Annual, monthly, or other periodic billing and/or account statements for your account(s)
- Appointment reminders

I understand that electronic communication will be processed, in the event I do not receive a response, I understand that I should contact the office directly.

I understand this service is offered free of charge, however standard text message rates from my mobile carrier may apply.

I understand that I am responsible for notifying *Rodgers Stein Chiropractic Center* when my contact information changes.

I hereby give *Rodgers Stein Chiropractic Center* permission to send messages to me via email and/or text messaging as means of communication, despite that such electronic communication methods can lack any guarantee of privacy.

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

E-Mail: _____

Cell Phone: _____

Rodgers Stein Chiropractic Center

PREGNANCY WAIVER

I hereby acknowledge that Rodgers Stein Chiropractic Center has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated on my own volition that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

Printed Name of Patient

Signature of Patient/Authorized Representative of Patient

Witness

Date

Doctor