

INTAKE FORM

Patient Information

Insurance Information

Patient Name _____
(last)

(first) _____ (middle initial) _____

Address _____

City _____ State _____ ZIP _____

Home Phone (____) _____ Cell Phone (____) _____

Email Address _____

SS# _____ Sex M F

Birth date _____ Age _____

Occupation _____

Employer _____

Work Phone (____) _____ Extension _____

Married Widowed Single Minor
 Separated Divorced Partnered for _____ years

IN CASE OF EMERGENCY

Name _____ Relationship _____

Home Phone (____) _____ Cell Phone (____) _____

Which of the following of our marketing have you seen?

Direct mail Friend: _____
 Internet Magazine(Which One _____)
 Radio Talk: _____
 Sign Other: _____

What specifically prompted you to choose us for your healthcare needs? _____

Name of Primary Care Provider: _____

City, State: _____

Last check up: _____

Are you under a doctor's care at the present time? Yes No

If yes, for what? _____

Name of Doctor: _____

City, State: _____

Primary Subscriber _____

Relationship to Patient _____

Insurance Co. _____

ID # _____

Is there a Secondary Insurance? Yes No

Insurance Co. _____

ID # _____

ASSIGNMENT AND RELEASE

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay 100% the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of any health insurance or medical plan benefits directly to Health First Wellness for medical services rendered and for any supplies, tests, or medications provided. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other legal remedies necessary in connection with same. I hereby assign directly to Health First Wellness all current and prior rights, if any, to payment and benefits and all legal and other health plan rights that I (or my child, spouse, or minor dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). This assignment includes, but is not limited to, a designation that Health First Wellness personnel can act on my / our behalf, as our representative or ERISA representative, as to any initial claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to Health First Wellness as a result of services rendered by Health First Wellness and authority to pursue any and all remedies to which I / we may be entitled, including the use of legal action against the health plan or insurer. This assignment and designation remains in effect unless revoked in writing, and a photocopy is to be considered as valid and enforceable as the original.

FINANCIAL POLICY

We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, Mastercard and Care Credit. I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Rep.

Date

Relationship to Patient

Surgical History	Nutrition
<p><i>Past Surgical History</i> _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Present Height: _____ feet _____ inches</p> <p>Present Weight: _____ lbs.</p> <p>Ideal Weight: _____ lbs.</p> <p>Weight at age 20: _____ lbs.</p> <p>Do you eat/snack after your evening meal? YES / NO</p> <p>If yes, what and how much do you eat? _____</p> <p>_____</p> <p>What beverages do you drink throughout a day? _____</p> <p>_____</p>

PHYSICAL MEDICINE CURRENT CONDITIONS
<p>Reason for Visit? _____</p> <p>When did your symptoms appear? _____</p> <p>Is this condition getting progressively worse? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____</p> <p>Type of Pain: <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Throbbing <input type="checkbox"/> Numbness <input type="checkbox"/> Aching <input type="checkbox"/> Shooting</p> <p><input type="checkbox"/> Burning <input type="checkbox"/> Tingling <input type="checkbox"/> Cramps <input type="checkbox"/> Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Other</p> <p>How often do you have this pain? _____</p> <p>Is it constant or does it come and go? _____</p> <p>Does it interfere with your <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Daily Routine <input type="checkbox"/> Recreation</p> <p>Indicate activities which are painful to perform: <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Bending <input type="checkbox"/> Lying Down</p> <p>What treatment have you already received for your condition? <input type="checkbox"/> Medication <input type="checkbox"/> Surgery <input type="checkbox"/> Physical Therapy</p> <p><input type="checkbox"/> Chiropractic Services <input type="checkbox"/> None <input type="checkbox"/> Other _____</p> <p>Name and address of other doctor(s) who have treated you for your condition: _____</p> <p>_____</p> <p>Date of Last: Physical Exam _____ Spinal Exam/X-Ray _____ Lab work _____</p> <p>Chest X-Ray _____ MRI, CT-Scan, Bone Scan _____</p> <p>Is your condition due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Accident: _____</p> <p>Type of Accident: <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other: _____</p> <p>To whom have you made a report of your accident? <input type="checkbox"/> Auto Insurance <input type="checkbox"/> Employer <input type="checkbox"/> Work Comp. <input type="checkbox"/> Other</p>

Name _____ Date _____

Please be sure to fill this form out extremely accurately. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.

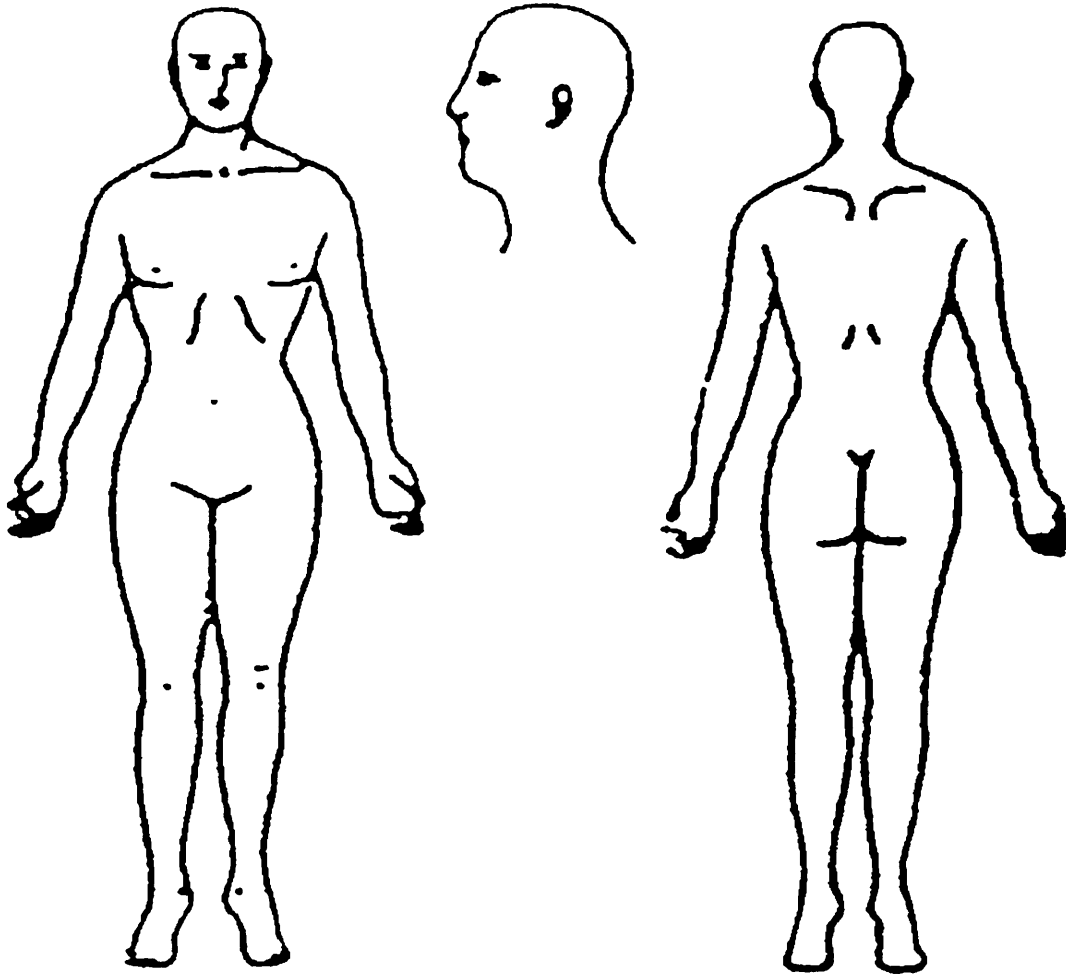
Aches $\wedge\wedge\wedge$

Numbness oooo

Pins/Needles ●●●●

Burning xxxx

Stabbing ///



Indicate the severity of your symptoms by marking an "X" on the lines below:

How bad are your symptoms now?

None Most Severe

How bad have they been in the past?

None Most Severe



X-ray Consent:

I authorize the use of diagnostic x-rays if the doctor deems it necessary or advised in my treatment. Every effort will be taken by the doctor to conform with the Illinois Department of Radiation Bureau's Regulations when it comes to radiation exposure.

Signature _____

Date _____

Minor:

I am the Parent/Legal Guardian of _____ and authorize the use of diagnostic x-rays if the doctor deems it necessary or advised in my treatment. Every effort will be taken by the doctor to conform with the Illinois Department of Radiation Bureau's Regulations when it comes to radiation exposure.

Parent/Legal Guardian Signature _____

Date _____

Females Only:

Pregnancy Release:

I certify that, to the best of my knowledge, I am not pregnant. I authorize the use of diagnostic x-rays if the doctor deems it necessary or advised in my treatment. Every effort will be taken by the doctor to conform with the Illinois Department of Radiation Bureau's Regulations when it comes to radiation exposure. I have been advised that certain x-ray examinations, especially of the pelvis, can be harmful to an unborn child.

Signature _____

Date _____



HIPPA and Cancellation Policy

NAME: _____ ADDRESS: _____
DATE OF BIRTH _____

HIPPA Release of Medical Records:

I authorize any, legal representative, attorney, medical, psychological, psychiatric, osteopathic or chiropractic physician, any other medical practitioner of healthcare provider, hospital, clinic, rehabilitation facility to disclose information from the medical and health care records/bills of the injured person. I understand that the specific type of information to be disclosed includes but not limited to, breakdown of any settlement, medical records/bills, including history, treatment, diagnosis, and billing records. This authorization also permits discussion in person, by telephone, electronically, or by mail.

Consent to Treatment & Release of Information:

I voluntarily consent to receive medical and health care services that may include diagnostic procedures examinations and treatment. I authorize the release of any medical information necessary to process this claim. The risks and benefits of therapy have been explained to me.

Cancellation Policy

In order to provide equal opportunity to all our patients and provide the best care possible, we really need your cooperation with keeping up with your appointments. Maintaining your schedule will help us give you the best clinical outcome possible.

Please kindly give **24 hour notice** if you are unable to keep your appointment, otherwise you will be charged a cancel fee of:

Physical Therapy/Chiropractic Cancel- \$30
Behavioral Therapy Cancel Fee- \$50
Dietician Cancel Fee- \$45

Massage Cancel Fee- \$30
Naprapathic Cancel Fee- \$75
Court Representation Hourly- \$300

I certify that I have read this form and understand its contents. I agree to the terms and agree to abide

Name: _____

Date: _____

Signature: _____