Patient Name: _____

chirotrendz
family chiropractic and wellness center
keeping things in motion

New Patient Physical Intake Form

Informed Consent | Financial Policy | Privacy Policy

Date_____

☐MWP_____ ☐PI ☐WC ☐VA ☐MEDICARE ☐INS

☐Patient Demographics

FULL NAME_____ **PREFERRED NAME**_____ **DATE OF BIRTH** _____

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP** _____

SEX □ Male □ Female **MARITAL STATUS:** □ M □ S □ W □ D **NUMBER OF CHILDREN?** _____

CELL PHONE _____ **HOME PHONE** _____ **E-MAIL**_____

Preferred method of communication. □ Cell Phone □ Home Phone □ E-mail □ Other _____

How did you hear about us? _____ **EMPLOYER**_____ **WORK PHONE**_____

NAME OF SPOUSE/SIGNIFICANT OTHER_____ **PHONE** _____

EMERGENCY CONTACT_____ **RELATIONSHIP** _____ **PHONE** _____

CONSENT TO PHYSICAL EXAMINATION

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions if there is anything that is unclear before you sign.

Physical Examination

In order to determine the overall health of individuals before participation in activities, many schools, organizations, and church and civic groups require a pre-participation examination or physical to evaluate or detect whether the individual is in general good health, the individual's present fitness level, conditions that may predispose the individual to new injuries, existing injuries of the individual, the size and developmental maturation of the individual, congenital anomalies that may increase the individuals' risk of injury, and poor conditioning that may put the individual at increased risk of injury or death.

During the examination the doctor will perform some procedures or maneuvers intended to evaluate your overall health which will allow for a better understanding of the nature of your current physical condition.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or have had read to me the above explanations regarding the physical examination and have discussed it with the Doctors at ChiroTrendz Family Chiropractic and Wellness Center and have had my questions answered to my satisfaction.

If the patient is a minor, I hereby authorize the doctors and staff at ChiroTrendz Family Chiropractic and Wellness Center to examine my child and to treat his/her condition as deemed appropriate, which may or may not include diagnostic imaging.

Date _____ Date _____

_____
Printed Name of Patient *or* Parent/Guardian

DOCTOR OF RECORD
Jason McDonald, DC Kolby Wolfley, DC

_____
Signature of Patient *or* Parent/Guardian

_____
Signature of Doctor

Patient Name: _____

ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that ChiroTrendz Family Chiropractic and Wellness Center will help prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to ChiroTrendz Family Chiropractic and Wellness Center will be added to my account.

I hereby assign all medical and chiropractic benefits to which I am entitled to ChiroTrendz Family Chiropractic and Wellness Center. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other medical plan, to issue payment check(s) or direct deposits directly to ChiroTrendz Family Chiropractic and Wellness Center for medical or chiropractic services rendered to myself and/or my dependents.

I acknowledge that ChiroTrendz Family Chiropractic and Wellness Center **CAN NOT** guarantee that my insurance company will pay. Prior to or immediately after my first visit, ChiroTrendz will make every attempt to receive and verify benefits and coverage of my insurance policy. If I seek treatment outside of ChiroTrendz Family Chiropractic and Wellness Center, my remaining benefits may not be accurate and claims may be denied due exhausted benefits. I will let ChiroTrendz know when I seek care elsewhere so that claims are not denied and financial responsibility isn't shifted to me, the patient.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that I am responsible for any amount not covered by insurance. I also understand that if I suspend or terminate my care and treatment or insurance policy, any fees for professional services rendered to me will be immediately due and payable.

_____ _____ _____

Printed Name of Patient *or* Parent/Guardian | Signature of Patient *or* Parent/Guardian | Date

ACKNOWLEDGEMENT OF REVIEW OF PRIVACY PRACTICES

I have reviewed ChiroTrendz Family Chiropractic and Wellness Center's Notice of Privacy Practices, which explains how my Protected Health Information (PHI) will be used and disclosed. I have had my questions satisfactorily answered considering this policy. I understand that I am entitled to receive a copy of this document upon request at any time. I also acknowledge that I may review the policy anytime online at http://www.chirotrendz.com/privacy.html and that changes will be reflected there immediately.

I hereby grant unto ChiroTrendz Family Chiropractic and Wellness Center the right to post my feedback and testimonial of care on social media and company websites when I leave such feedback. If you do not want your feedback posted please let us know at any time and we will remove it.

_____ _____ _____

Printed Name of Patient *or* Parent/Guardian | Signature of Patient *or* Parent/Guardian | Date

FOR OFFICE USE ONLY

ChiroTrendz LLC attempted to obtain written acknowledgment of receipt or review of our Notice of Privacy Practices, but acknowledgment could not be obtained because (please specify) _____

_____

Date _____ Staff Signature _____