

Tri County Chiropractic and Rehabilitation, P.C.
 1954 E. High Street Pottstown, PA 19464 – 610-327-8090
 312 Lincoln Hwy., Exton, PA 19341 – 484-879-6968

Patient Intake Form

Patient Information

Full Name: _____ Birth Date: _____
 Address: _____ Apt. # _____
 City: _____ State: _____ Zip: _____
 Age: _____ Female: _____ Male: _____
 Home Phone: _____ Work Phone: _____ Cell/Other: _____
 I prefer to receive calls at (circle) Home / Work / Cell
 I am (Circle one): Under age 18 / Single / Married / Divorced / Widowed / Separated / Partnership
 Email: _____
 Family Doctor: _____ Telephone: _____
 Employer: _____ Occupation: _____
 Business Address: _____ City: _____ State: _____ Zip: _____
 Spouse's Name: _____ Spouse's Date of Birth: _____
 Emergency Contact: _____ Emergency Contact Phone Number: _____

IS THIS A WORK-RELATED ACCIDENT OR MOTOR VEHICLE ACCIDENT? _____

Who referred you to us or how did you hear about us? _____

Payment Information

Person Responsible for Payment: _____
 Phone: _____ Date of Birth: _____

Insurance Information

Do you have health insurance? _____ Yes _____ No

Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's Birth Date:	Policy Holder's Birth Date:
Group Number:	Group Number:
Policy ID Number:	Policy ID Number:

Please have your insurance card and driver's license ready so they can be copied for the clinic's records.

Consent for Treatment

Assignment & Release – By signing below, I authorize Tri County Chiropractic to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Tri County Chiropractic, and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.

By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.

Signed _____ Date _____

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History of Treatment

Primary care Physician: _____ Phone: _____

Date last seen: _____ May we update them on your condition? ___Yes ___No

Have you seen a chiropractor before? ___No ___Yes, when and why? _____

Name of previous chiropractor: _____

Have you seen another doctor for these symptoms? IF yes, indicate name and type of medical provider: _____

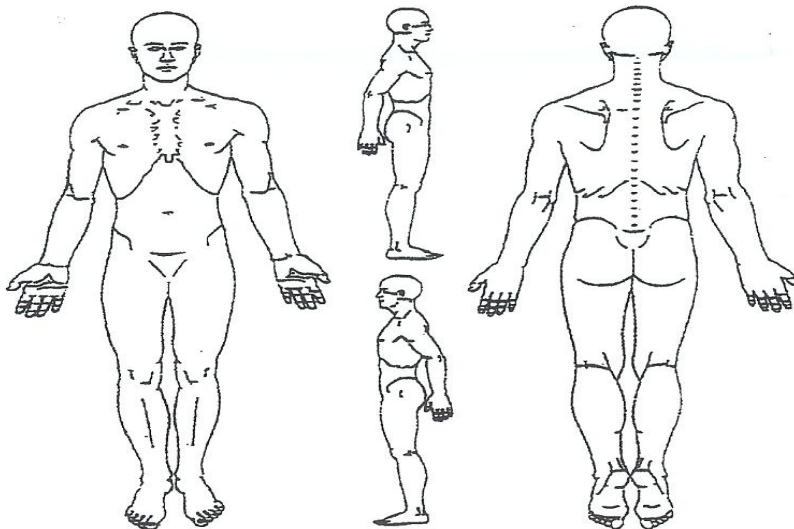
List all prescription, non prescription medications, and other supplements you take as well as the associated condition:

List any falls, head injuries, broken bones, dislocations, surgeries, hospitalizations, or imaging (i.e. x-rays, MRIs, etc) you have had complete with the month and year for each: _____

Description of Condition

Mark any area(s) of discomfort with the following key:

A=Ache N=Numbness B=Burning T=Tingling S=Stiffness O=Other



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Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You may have the right to review that notice before you sign this consent form (act 164.520). We reserve the right to change our privacy practices as described in the notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke Your Authorization

You may revoke your consent to us at anytime; however, your revocation must be in writing. We will not be able to honor your revocation request if we already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am acknowledging that I have received a copy of this notice.

Print Name: _____

Signed: _____

Date ____/____/____

Print patient name if minor: _____

TCC Witness: _____

Tri-County Chiropractic and Rehabilitation, P.C.

INSURANCE AND PAYMENT CONTRACT

DEDUCTIBLE INFORMATION: It is your responsibility to know and understand your benefits. If your insurance plan has a deductible, Tri County Chiropractic will collect a partial payment at the time of service and the responsible party will be billed for the remaining amount, if any.

- 1) You authorize your insurance company to pay Tri-County Chiropractic, PC all insurance benefits otherwise payable to you for services rendered. You authorize the use of your signature on all insurance forms and submissions.
- 2) At the beginning of your treatment, or if your insurance changes, our office will make every attempt to verify your policy benefits. However, this office DOES NOT guarantee your insurance policy or payments. In addition, this office is not responsible for inaccurate information quoted by your insurance company.
- 3) If your insurance company has not paid the full balance within 60 days of receiving a claim, a statement will be sent to you requesting payment within 20 days. You will be informed in writing when your account is past due. If payment or payment arrangements are not made, collection will be made through a collection agency. Balances older than 90 days are subject to collection action, as well as collection fees and interest.
- 4) Copayments and/or co-insurance are due at the time of visit unless prior arrangements were made.
- 5) You authorize Tri-County Chiropractic, PC to release all information necessary to secure payments of benefits. You understand that it is YOUR responsibility for all charges whether or not paid by insurance
- 6) If your insurance company requires a referral from your Primary Care Physician, it is your responsibility to obtain a referral for care.
- 7) You understand that if you do not cancel your appointment 24 hours in advance or do not show, you may be charged a \$25.00 fee.
- 8) In some instances, your insurance company may require additional information from you before they will process your claim. It is your responsibility to contact your insurance company with any requested information in a timely manner.
- 9) You permit a copy of this authorization to be used in place of the original.

AUTHORIZATION FOR CHIROPRACTIC TREATMENT

I, the undersigned, a patient or parent/guardian of the minor patient in this office hereby authorize Dr. Christine Treacy, Dr. Jessica Kennedy, Dr. Jessica Krishnakumar and whomever they may designate as their assistants to administer treatment as is necessary and to perform therapies, manipulations and procedures as are considered therapeutically necessary on the basis of finding during the course of said treatments.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems. I am aware that there are possible risks and complications associated with these procedures as follows:

- Soreness: I am aware that, like exercise, it is common to experience soreness in the first few treatments. I am aware that if soreness continues the doctor should be notified.
- Dizziness: temporary symptoms such as dizziness or nausea may occur but are very rare. If dizziness occurs the doctor should be notified.
- Fractures/ joint injury: I understand that in isolated cases physical defects, deformities, or pathologies are detected or suspected this office will process with extra caution.
- Stroke: Stroke from chiropractic care is extremely rare. I am aware that strokes are reported to occur once in one million to once in ten million treatments. Once in one million is about the same risk as getting struck with lightning. Once in ten million is about the same as a normal one time dose of acetaminophen causing death.

Treatment Results

I also understand that there are beneficial effects associated with chiropractic treatment including:

Decreased Pain	Improved Mobility
Reduced Muscle Spasm	Improved Function
Improved Flexibility	Increased Range of Motion

Alternate Treatments Available

I understand that there are reasonable alternatives to care including but not limited to rest, home applications of therapies, prescriptions or over the counter medication, exercises and possibly surgery.

Non-Treatment

I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery more difficult and lengthy.

I hereby certify that I have read and fully understand the above explanation to chiropractic treatment. Any questions I have regarding these procedures have been answered to my satisfaction prior to signing this consent form. I have made my decision voluntarily and freely.

To attest my consent for these procedures, I hereby affix my signature to this authorization for treatment. I also fully understand and agree to the financial policy.

Print Name: _____

Print patient name if minor: _____

Signed: _____

Date ____/____/____

TCC Witness: _____