THE BACK ALLEY
CHIROPRACTIC & MASSAGE

RE-EXAM INTAKE

Please take the time to complete these forms to the best of your ability. If you have any questions, we will be glad to help you.

First Name _____ **Middle** Initial _____ **Last** Name _____

Home Address _____

City _____ State _____ Zip Code _____

Billing Address (*if different*) _____

City _____ State _____ Zip Code _____

Email Address* _____

Cell Phone _____ Would you like to receive text reminders? ☐ Yes ☐ No

Home Phone _____ **Work** Phone _____

Emergency Contact Name _____ Phone # _____

Primary Care Physician _____ Phone # _____

Date of Birth _____ / _____ / _____ Social Security Number _____ - _____ - _____

Employment Status: ☐ Employed _____ ☐ Not Employed ☐ Retired ☐ Student
(employer name)

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

COVERAGE INFORMATION

If you are **Self Pay**, please request a copy of our updated fee schedule.
If you are **Insured**, complete below as listed on your insurance card, sign where indicated, then provide your insurance card(s) to reception. Digital cards should be emailed to thebackalleychiro@yahoo.com.

Primary Insurance_____ ID # _____ Insured: ☐Self ☐Spouse ☐Parent ☐Other

Insured: Full Name _____ Phone # _____ Date of Birth _____/_____/_____

Social Security Number _____ - _____ - _____ Employer _____

Secondary Insurance_____ ID # _____ Insured: ☐Self ☐Spouse ☐Parent ☐Other

Insured: Full Name _____ Phone # _____ Date of Birth _____/_____/_____

Social Security Number _____ - _____ - _____ Employer _____

I authorize the release of any medical or other information necessary to process my claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

I authorize payment of medical benefits to The Back Alley Chiropractic and its physicians or supplier for services received.

To the best of my ability, the information I have supplied is complete and truthful. I grant permission to be called or emailed to confirm or reschedule an appointment and to be sent occasional cards, letters, or emails as an extension of my care in this office.

*Providing an email is explicit consent and agree to receive communication and marketing emails (see our HIPAA notice for more details).

Patient or Parent/Guardian Signature _____ Date _____

INSURANCE POLICY & PROCEDURES

All policies and procedures are available on our website for reference at any time. Office policies and procedures are updated regularly. Your signature below indicates you have read, understand, and agree to the above policy and procedures regarding insurance coverage billing practices.

- The Back Alley Chiropractic fully complies with all our insurance contracts. It is not our custom to balance bill amounts not allowed by your insurance policy. It is your responsibility to update us with your current insurance information. **If you fail to notify us of a change in carrier, termination of coverage, and/or exceeded benefits, you will be 100% responsible for payment per your insurance policy's allowable amount.**
- The Back Alley Chiropractic strives to contract with all local insurance plans. In special cases this may not be possible. Out-of-network coverage often requires a referral or pre-authorization by a Primary Care Physician (PCP). **It is your responsibility to know if a referral or pre-authorization is required to see specialists.** If a referral is required, it is up to you to arrange the submission per your insurance carrier by your PCP. If a referral is not received, you will be 100% responsible for payment.
- The Back Alley Chiropractic does its best to verify and interpret your benefits and eligibility with regard to chiropractic and therapeutic procedures. Occasionally we are given incorrect information and can make mistakes. You are responsible for balances owed if your Explanation of Benefits (EOB) shows a different amount owed from your verification. **Any questions about balances owed should be directed to your insurance carrier's member services.**
- According to your insurance carrier, you are responsible for co-pays, deductibles and/or co-insurances. **Co-pays, deductibles and/or co-insurances are fees that cannot be waived or discounted.** You will be responsible for your portion of the bill, which is due at the time of service, unless other arrangements have been requested in advance.
- If your insurance carrier is to be billed prior to payment collection, once we receive an EOB from your insurance carrier an itemized bill will be sent to you with any balance owed per your insurance plan.
- Any insurance you may have is an agreement between you and your insurance carrier and you are financially responsible for the payment of any services rendered.
- According to your insurance carrier, verification of your benefits is not a guarantee of payment and final determination will be made for payment of services ***after*** a claim is received. The Back Alley Chiropractic is committed to providing the best treatment for our patients. Our professional fees are usual and customary per local state and federal rate tables.

Print Patient Name _____

Patient or Parent/Guardian Signature _____ Date _____

ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE

You may request a copy of our HIPAA Privacy Notice to take home with you by requesting from any member of our staff.

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among health care providers who may be directly and indirectly involved in providing my treatment
- Obtain payment from third party payers
- Conduct normal health care operations such as quality assessments and accreditation

Patient or Parent/Guardian Signature _____ Date _____

CONSENT TO TREATMENT OF A MINOR

All minors must be accompanied by a parent/legal guardian for any service requiring an exam. Leave section blank if not applicable.

I, _____, hereby authorize The Back Alley Chiropractic & Massage clinic/doctors/assistants to administer chiropractic treatment as deemed necessary to my son/daughter/legal dependent. This authorization shall remain effective until _____/_____/_____, unless sooner revoked in writing.

Parent/Guardian Signature _____ Date _____

HISTORY OF PRESENT ILLNESS – CHIEF COMPLAINTS

List and describe your ***chief complaint(s)*** *and answer all questions following. If you need more space, please ask for an additional page.*

1)_____ How long ago? #____ Days #____ Weeks #_____ Months #____ Years

How did this begin? ☐ job related injury ☐ auto accident ☐ illness ☐ injury ☐ unknown ☐ gradual onset ☐ sudden onset

This occurs? ☐ seldom ☐ repeatedly ☐ frequently ☐ constant Severity: 0 1 2 3 4 5 6 7 8 9 10

How often? ☐ 0-25% ☐ 25-50% ☐ 50-75% ☐ 75-100% ☐ in the afternoon ☐ in the evening Intensity: ☐ light ☐ extreme

Condition is: ***Aggravated*** by_____ ***Improved*** by_____

2)_____ How long ago? #____ Days #____ Weeks #_____ Months #____ Years

How did this begin? ☐ job related injury ☐ auto accident ☐ illness ☐ injury ☐ unknown ☐ gradual onset ☐ sudden onset

This occurs? ☐ seldom ☐ repeatedly ☐ frequently ☐ constant Severity: 0 1 2 3 4 5 6 7 8 9 10

How often? ☐ 0-25% ☐ 25-50% ☐ 50-75% ☐ 75-100% ☐ in the afternoon ☐ in the evening Intensity: ☐ light ☐ extreme

Condition is: ***Aggravated*** by_____ ***Improved*** by_____

3)_____ How long ago? #____ Days #____ Weeks #_____ Months #____ Years

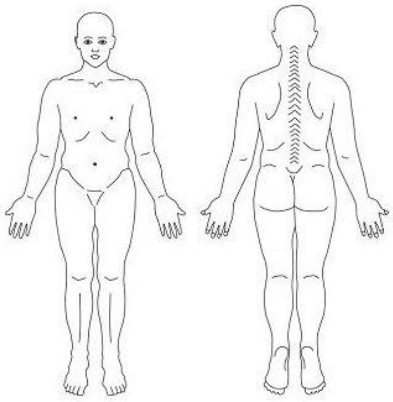
How did this begin? ☐ job related injury ☐ auto accident ☐ illness ☐ injury ☐ unknown ☐ gradual onset ☐ sudden onset

This occurs? ☐ seldom ☐ repeatedly ☐ frequently ☐ constant Severity: 0 1 2 3 4 5 6 7 8 9 10

How often? ☐ 0-25% ☐ 25-50% ☐ 50-75% ☐ 75-100% ☐ in the afternoon ☐ in the evening Intensity: ☐ light ☐ extreme

Condition is: ***Aggravated*** by_____ ***Improved*** by_____

Use the abbreviations to indicate your symptoms on the illustration on the appropriate body side. If both sides, **circle** the abbreviation.



BU = Burning **DP** = Dull Pain **H** = Heavy

HA = Headaches **NU** = Numb **S** = Sore

SP = Sharp Pain **SH** = Shooting Pain **SS** = Spasm

ST = Stiff **TH** = Throbbing **TI** = Tingling

O = Other _____

Height _____ft _____ in Weight _____ lb _____ oz

SOCIAL HISTORY

Smoking Use: ☐ Never ☐ Former ☐ Current If current smoker, how much daily? _____

Alcohol use: ☐ Never ☐ Daily ☐ Weekends ☐ Occasional

Recreational Drug use: ☐ Never ☐ Daily ☐ Weekends ☐ Occasional

Print Patient Name _____

Patient or Parent/Guardian Signature _____ Date _____

PATIENT HISTORY

Check any conditions you have suffered from:

☐ Alcoholism	☐ Allergies	☐ Anemia	☐ Anxiety	☐ Arm Pain
☐ Arrhythmia	☐ Arteriosclerosis	☐ Arthritis	☐ Asthma	☐ Back Pain
☐ Bronchitis	☐ Bruise Easily	☐ Cancer	☐ Cold Extremities	☐ Depression
☐ Diabetes	☐ Digestion Problems	☐ Dizziness	☐ Ears Ringing	☐ Emphysema
☐ Epilepsy	☐ Fainting	☐ Fatigue	☐ Fibromyalgia	☐ Foot Pain
☐ Gout	☐ Headaches	☐ Heart Attack	☐ Heart Disease	☐ High Blood Pressure
☐ Hip Pain	☐ HIV Positive	☐ Insomnia	☐ Kidney Infection	☐ Kidney Stones
☐ Knee Pain	☐ Leg Pain	☐ Loss of Balance	☐ Loss of Memory	☐ Loss of Smell
☐ Low Back Pain	☐ Migraines	☐ Neck Pain	☐ Nosebleeds	☐ Osteoarthritis
☐ Osteopenia	☐ Osteoporosis	☐ Polio	☐ Poor Circulation	☐ Poor Posture
☐ Rheumatoid Arthritis	☐ Sciatica	☐ Shoulder Pain	☐ Sinus Infection	☐ Spinal Curvature
☐ Stroke	☐ Swollen Joints	☐ Thyroid Condition	☐ TMJ	☐ Tuberculosis
☐ Tumor	☐ Ulcers	☐ Upper Back Pain	☐ Varicose Viens	☐ Other

Additional Comments regarding Patient History: _____

_____

_____

MEDICAL HISTORY

Check any trauma, injury, procedure, surgery you have experienced:

☐ Appendectomy	☐ Back Surgery	☐ Broken Bone	☐ Car Accident	☐ Chemotherapy
☐ Cosmetic Surgery	☐ Dislocation	☐ Fracture	☐ Gastric Bypass	☐ Heart Bypass
☐ Hysterectomy	☐ Joint Replacement	☐ Knocked Unconscious	☐ Neck Surgery	☐ Nerve Injury
☐ Pacemaker	☐ Radiation Therapy	☐ Spinal Fusion	☐ Spine Injury	☐ Spine Surgery
☐ Surgery	☐ Traumatic Brain Injury	☐ Tonsillectomy	☐ Trauma	☐ Other

Additional Comments regarding Medical History: _____

_____

_____

MEDICATIONS

List any prescribed or over the counter medications, vitamins, and supplements: _____

_____

_____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern. Inaccurate information could be dangerous to my health. If there is any change in my medical status I will notify the chiropractor immediately. I authorize the chiropractor and staff to perform any necessary services needed during diagnosis and treatment.

Print Patient Name _____

Patient or Parent/Guardian Signature _____ Date _____

OFFICE POLICY

Appointments 1) We value the time we have set aside to see you. The Back Alley Chiropractic is a multiple provider office and we must often schedule overlapping appointments according to the service requested and depending on the treatment required. 2) Walk-ins are ***always*** welcome, however, appointments will be seen first. 3) If you are late for your appointment, we will do our best to accommodate you. 4) We strive to minimize wait time, however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.

If you have not been seen in our office in 18 months or longer, or if you have a new or different injury, a re-exam will be carried out and charged to you or your insurance carrier. If you have not been seen in our office in 3 years or longer, you are considered a new patient.

Self-Pay Patients 1) We welcome patients whose insurance companies are out-of-network, do not provide chiropractic benefits, or are uninsured. 2) We recommend you keep a copy of our updated fee schedule for your records. All payments are to be paid in full at the time services are rendered. 3) Insurance ***cannot*** be used when opting for a Prompt Pay Fee service discount.

FINANCIAL POLICY

Payment We accept cash, check, and debit, Visa, MasterCard and Discover. There is a minimum fee of $25 charged for returned checks.

Insured By request, as a courtesy to our patients, we will submit your medical claim to your insurance carrier. Patient balances are billed immediately upon receipt of your carriers EOB. Your remittance is due immediately upon receipt of our bill.

Self-Pay We offer a Prompt Pay fee discount for all patients by request. If you fail to provide payment at the time services are rendered, you will be responsible for and billed for 100% of the professional fee. You can request a copy of our updated fee schedule at any time.

Delinquent Accounts Unpaid balances are past due at 30 days. Balances left unpaid may receive a second and third notice prior to final notice, mailed at 30-day intervals. The Back Alley utilizes an outside collection agency. Balances over 120 days past due may be submitted to our collection agency.

Medicare We accept Medicare assignment. As a Medicare patient you are responsible for your deductible and co-insurance. If you have secondary or supplemental insurance we will bill it for you. Medicare non-covered services are due at the time of service.

Workers Compensation If you are here as a result of a work related injury, we will require information regarding your health insurance and your employers Workers Compensation insurance.

Personal Injury Claims We bill third party insurance carriers ***only*** on a lien basis. Please notify our staff of your personal injury immediately. You will be asked to complete forms specific to personal injury as well as a consent and notice for medical lien. By consenting to Medical Lien, you elect not to use any coverage potentially available under a health insurance or similar medical benefit plan that may cover you, the injured, as an insured or dependent.

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatment (also known as CMT, chiropractic adjustments or chiropractic manipulative treatment) and any other associated procedures; physical examination, tests, diagnostic x-rays, physiotherapy, physical medicine, physical therapy procedures, etc. on me by the Doctor of Chiropractic named and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedure, that there are certain complications that may arise during CMT. 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 facts known, are in my best interest. I have had the opportunity to discuss nature, purpose and risks of chiropractic treatment and other recommended procedures with the doctor and/or with office staff and/or clinic personnel.

I have read, or have had read to me, the above explanation of the CMT. I state that I have been informed and weighed the risks involved in CMT. I have decided that it is in my best interest to receive CMT. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

I have read and understand the above policies and agree to accept responsibility for any and all payment(s) due as outlined.

Print Patient Name _____

Patient or Parent/Guardian Signature _____ Date _____