Rushmore Family
CHIROPRACTIC

NEW PATIENT INFORMATION

Today's Date: _____

PATIENT INFORMATION

Name: _____ Nickname: _____

Reason for Visit:_____

_____

Gender: M / F Marital Status: S / M / W / D Phone Number: _____

Date of Birth: _____ Age:_____ SSN: _____-_____-_____

Mailing Address:_____ City: _____ State:_____ Zip:_____

Email Address:_____

Employer:_____ Job Title:_____

How did you hear about us? _____

Emergency Contact Information

Name: _____ Relation: _____ Phone _____

INSURANCE INFORMATION

If you want us to bill insurance, please fill out the following information. We will also need a copy of the insurance card. If you are planning on paying our time of service price, please disregard.

Insurance Company: _____ Name of Policy Holder: _____

Subscriber ID #_____ Group #_____

PATIENT INFORMED CONSENT

I,_____, the undersigned, consent to care at this clinic. I understand that I have the opportunity to discuss with the doctor and/or with other office personnel, the nature and purpose of chiropractic adjustments and progressive wellness. I hereby request and consent to performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient above, for whom I am legally responsible) by the doctor of chiropractic and support team at Rushmore Family Chiropractic. I also understand that as is with healthcare treatments, results are not guaranteed, there is no promise to cure and that there are some risks. Risks include, but are not limited to; aggravating and/or temporary increase in symptoms, muscle spasms, fracture, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor's judgment, based upon the facts then known, is in my best interests. I further understand that chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures.

I have read, or have had red to me, the above consent. I have also had an opportunity to ask questions about this content, and by signing below I agree to the above-named procedures.

Patient Signature _____

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PRIMARY COMPLAINT

Primary complaint and its location: _____

_____

How often do you experience this pain (circle all that apply)? Constantly Frequently Intermittently Occasionally

What caused the onset?_____Date of the onset: _____

On a scale of 0 to 10, 0 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of their pain:

0 = None **1** = Minimal **2** = Very Mild **3** = Mild **4** = Mild to Moderate **5** = Moderate **6** = Moderate **7** = Mildly Severe, Restricts Some Activity **8** = Severe, Limits Most Activity **9** = Very Severe **10** = Excruciating

Sitting here today, right now, what is the intensity of their pain on the scale of 0 to 10? 0-10: _____

What is the least intense the symptom has been on the scale of 0 to 10? 0-10: _____

What is the most intense the symptom has been on a scale of 0 to 10? 0-10: _____

Would you describe your pain as (circle all that apply):

Sharp Stiff Spasms Stabbing Aching Pins & Needles

Shooting Pounding Burning Dull Tingling/Numb Throbbing Crawling Stinging

Does your pain radiate or travel? _____ If yes, where to? _____

What makes the pain feel worse or aggravates it (circle all that apply)?

Sneezing Lifting Exercising Looking up/down Walking Coughing Sitting Stooping Looking side/side Standing

Stress Driving Getting out of bed Pushing Pulling Repetitive movements Carrying Straining at BM Climbing stairs

Getting in/out of cars OTHER:_____

What helps relieve the pain (circle all that apply)?

Resting Sleeping Lifting Exercising Looking up/down Shower Advil Stooping Looking side/side Ice

Other:_____

Over the past week/month this complaint is (circle all that apply): Improving Getting worse About the same

What has your pain kept you from doing? _____

Have you seen anyone for this complaint? YES / NO If yes, who? _____ When? _____

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SECOND COMPLAINT

Description of pain/complaint:

_____

_____

Location of pain/complaint:_____

Sitting here today, right now, what is the intensity of their pain on the scale of 0 to 10? 0-10: _____

What is the least intense the symptom has been on the scale of 0 to 10? 0-10: _____

What is the most intense the symptom has been on a scale of 0 to 10? 0-10: _____

Would you describe your pain as (circle all that apply):

Sharp Stiff Spasms Stabbing Aching Pins & Needles Shooting Pounding Burning Dull

Tingling/Numb Throbbing Crawling Stinging

Over the past week/month this complaint is (circle all that apply): Improving Getting worse About the same

THIRD COMPLAINT

Description of pain/complaint:

_____

_____

Location of pain/complaint:_____

Sitting here today, right now, what is the intensity of their pain on the scale of 0 to 10? 0-10: _____

What is the least intense the symptom has been on the scale of 0 to 10? 0-10: _____

What is the most intense the symptom has been on a scale of 0 to 10? 0-10: _____

Would you describe your pain as (circle all that apply):

Sharp Stiff Spasms Stabbing Aching Pins & Needles Shooting Pounding Burning Dull

Tingling/Numb Throbbing Crawling Stinging

Over the past week/month this complaint is (circle all that apply): Improving Getting worse About the same

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GENERAL INFORMATION

Have you seen a chiropractor before? YES NO If yes, who and when? _____

Please list any medications that you are currently taking:

_____ _____

_____ _____

_____ _____

Please list any past surgeries or hospitalizations:

1:_____ Year_____ 2:_____ Year_____

3:_____ Year_____ 4: _____ Year_____

5:_____ Year_____ 6: _____ Year_____

Please list any other key slips, falls, or accidents that you've had from childhood to present:

_____

_____

Please circle any current or past medical conditions:

Fatigue	Fever	Chills	Night Sweats	Fainting	Nervousness	Concentration Loss
Depression	Memory Loss	Headaches	Muscle Pain	Muscle Weakness	Muscle Cramps	Irritability
Tremors	Stiff Neck	Back Pain	Hot Joints	Joint Swelling	Lumps/Masses	Spinal Curvature
Seizures	Dizziness	Paralysis	Loss of Sensation	Loss of Coordination	Cancer	Joint Stiffness
Stroke	Asthma	HIV	Angina/Chest Pain	Diabetes	Arthritis	Thyroid Problems
Heart Attack			Other:_____			

How frequently do you exercise (circle all that apply)? Never Rarely Occasionally Moderately Regularly

What is the intensity of your exercise (circle all that apply)? Low Level Medium Level High Level Competition Level

Are you currently pregnant or think that you may be pregnant? YES NO NA

If you have children, how many do you have? _____

Rushmore Family
CHIROPRACTIC

Financial Policy

Insurance Coverage

Welcome to Rushmore Family Chiropractic**.** Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the beneficiary to pay co-insurance, co-payment and/or a deductible. For example: if you have a deductible of $100, and your insurance pays 80%, you are responsible for 20% of all charges incurred during the year after you have paid your $100 at the beginning of the year. Our clinic will call your insurer to verify your benefits; however, we are not responsible for your insurer's final payment and benefit determinations.

Payments

In order to help you determine your responsibility toward payment for services, please read the following, and initial your preference for the method of payment of your account. Please notify this office if the status of your insurance changes.

Private Pay: (please initial)

A_____ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

B_____ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

Health Insurance: (please initial)

C_____I would like this clinic to bill my insurance. I understand I am responsible for the costs of treatment.

Missed Appointments

It is the policy of Rushmore Family Chiropractic to assess a **$50** missed visit fee to patients who cancel appointments with less than a 24-hour notice. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others.

_____ My initials here indicate that I understand the above missed visit policy.

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.

_____ _____

Signature Date

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CHIROPRACTIC

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Rushmore Family Chiropractic.

I understand that the Notice describes the uses and disclosures of my protected health information by Rushmore Family Chiropractic and informs me of my rights with respect to my protected health information.

_____ _____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____

_____ _____

Employee Name *Today's Date*