Hamilton Chiropractic

215 N San Mateo Dr. Ste 10
San Mateo, CA 94401

650-394-6045
www.hamiltonchiros.com

Intake Form

Full Name:_____ Date: _____/_____/_____
Street Address:_____
City_____ State_____ Zip_____
Phone Number: (_____)_____-_____ (home) (_____)_____-_____ (cell)
Email: _____ DOB:_____/_____/_____
Marital Status: Single_____ Married_____ SSN:_____
Spouses Name:_____ Children: #_____ Pregnant?(weeks)_____
Occupation: _____ Employer: _____

How did you hear about us? _____
Who referred you? _____
Have you ever been to a chiropractor? Yes No When/Why?_____

Current Issue That Brought You In Today:
New Injury: Yes No Date of New Injury:_____/_____/_____
Exacerbation of old injury: Yes No Date of Original Injury _____/_____/_____
Is this related to a work injury? Yes No Auto Accident? Yes No
Describe what you are experiencing:

_____
_____
_____
_____

On a scale (1-no pain, 10-excruciating pain) where would you rate this pain? (please circle one)
1 2 3 4 5 6 7 8 9 10
Additional Complaints:

_____
_____

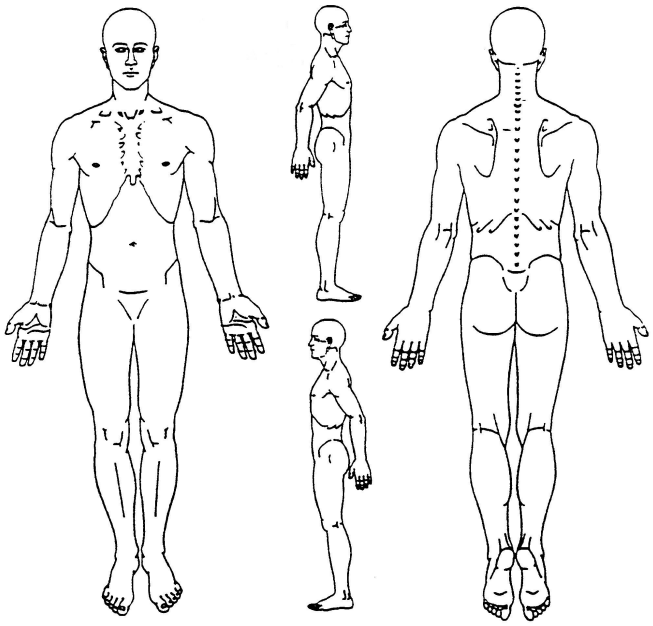
For additional complaints-On a scale where would you rate this pain? (please circle one)
1 2 3 4 5 6 7 8 9 10

Have you seen any other healthcare providers for this complaint? Yes No
Please describe:_____

Are the symptoms getting: Better Worse Staying the same

Please mark where you are experiencing the pain or discomfort on the body by placing the symbol below for each symptom:

Stabbing..... x
Throbbing..... o
Shooting/Sharp..... v
Ache/Dull..... d
Numb..... n



How often do you have this pain? (circle one)
Constantly (100%) Frequently (75%) Intermittent (50%) Occasionally (25%) Rarely (<25%)
What makes it better?_____
What makes it worse?_____
Does this interfere with your...(circle one)
Work Sleep Recreation Daily activities Home Other
Does your pain wake you from sleep? Yes No

Past Medical History:

Have you experienced any of the following: (Mark all that apply)

___ Headaches
___ Hearing loss/aides
___ Stroke
___ Sore throats
___ Scoliosis
___ Concussions
___ Numbness/Tingling
___ Knee Problems
___ Sprained Ankle(s)
___ Back Pain
___ Constipation
___ Irritable Bowel
___ Thyroid Problem
___ Lung disease
___ HIV
___ Mononucleosis
___ Night Sweats
___ Diabetes
___ Sinus issues/allergies
___ Heart attack/Heart Problem
___ Ear infections
___ Chest pain
___ Loss of breath/Asthma
___ Dizziness/Fainting
___ Sciatica
___ Foot/Ankle Pain
___ Neck Pain
___ Arteriosclerosis
___ Sleep Disorder
___ Digestion Problems
___ Liver Problem
___ Menstrual Irregularity
___ Hepatitis
___ Anemia
___ Weight Loss
___ Limb Edema
___ Eczema/skin irritations
___ Glasses/Eye problems
___ Jaw Paint/TMJ Disorder
___ Herniated/bulging discs
___ Seizures/Epilepsy
___ Arthritis/Joint Pain
___ Carpal Tunnel Syndrome
___ Wrist/Hand Pain
___ Shoulder Pain
___ High Blood Pressure
___ Osteoporosis ('penia)
___ Kidney Problem
___ Gall Bladder Problem
___ Prostate Problems
___ Uterus/Ovary Problems
___ Excessive Thirst
___ Frequent Urination
___ Bruise Easily

___ Chronic Fatigue ___ Lyme's Disease ___ Anxiety
___ Depression ___ Chemical Addiction ___ Eating Disorder
___ Chronic Cough ___ Cancer ___ Lumps/Tumors

Have you had any surgeries or hospitalizations?

_____

_____

Have you had any illnesses or major injuries?

_____

_____

Any family history of Cancer? _____ Diabetes?_____ Heart conditions?_____
Are you taking any Medications or vitamins? If so, which ones?

_____

_____

Do you exercise? If so, what do you do and how many times per week?

_____

_____

Do you: Smoke Yes No How often?_____
Alcohol Yes No How often?_____
Soda Yes No How often?_____
Please describe your diet:

_____

_____

_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors of omissions that I may have made in completion of this form.

Patient Signature: _____ Date: _____

Financial Policy

Restoring your health is our foremost objective. Our treatment will always be rendered solely on the base of need. Please advise us if you are unable to fulfill this policy so that we may discuss and consider alternative payment options. We require payment at the time of service unless special arrangements have been previously made. Our fees comply with the usual and customary rates for this region. We accept checks, cash, or credit card payments.

MEDICARE: Medicare pays for only a portion of chiropractic services and limits the number of reimbursements treatments. Reimbursable care is limited to spinal manipulation and does not include other therapies, services, and goods that may be necessary during care. Please be advised of the following Medicare restrictions and regulations.

- Medicare will pay for a maximum number of treatments per calendar year, based on your diagnosis. When the maximum number of treatments has been rendered, payment is expected at the time of service.
- Medicare will NOT pay for an initial examination. This fee is the patient's responsibility and will not apply to the patient's deductible.

PERSONAL INJURY, WORKER'S COMPENSATION AND/OR LITIGATION: If your complaint is the result of an occupational or automobile accident, or if litigation is pending, please notify us. If an attorney is involved, patients are required to sign a Physician's Lien that will be forwarded to the attorney for signature. If we do not receive the signed lien from the attorney within 14 days, all services must be paid for by the patient at the time rendered. It is our policy to bill the insurance company directly and will provide the attorney with a statement.

Instances will arise when we exhaust all reasonable efforts to secure payments through your insurance company, but the insurance company refuses payment. We will do our best to assist you in securing payments, but all balances are ultimately your responsibility.

MISSED APPOINTMENTS: There is a missed appointment fee in the amount of the appointment ($65.00 or $75.00) charged for missed appointments without a **24-hour** notice. This charge is the patient's responsibility and cannot be billed by the insurance company. Missed appointments fees must be paid before scheduling subsequent appointments. We may request a deposit for future appointments. If more than three appointments are missed without notification, we will recommend you seek treatment at another facility, or schedule care when you are able to commit to the recommended treatment program.

In fairness to our patients who do pay for service, after reasonable efforts on our part to obtain payment, we will solicit the service of a collection agency if necessary.

I have read this financial policy and understand that I am financially responsible for all unpaid balances for my care.

Patient Signature:_____ Date: _____

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you a copy of 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 have the right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy practices as described in that 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 limited 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 any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you are required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

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

_____ _____
Patient Name Authorized Provider Representative

_____ _____
Signature Date

_____
Date

CHIROPRACTIC TREATMENT INFORMED CONSENT

The nature of the chiropractic manipulation: The primary treatment used by doctors of chiropractic is manual manipulation, also known as adjustment. I will use that and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques to treat the patient now and in the future. I will apply my hands to the area of your body to be treated in such a way as to move your joints. This may cause an audible “pop” or “click” similar to when you “crack” your knuckles. You may feel or sense movement.

The materials risks inherent in chiropractic adjustment: There are potential complications that may arise with any health care procedure. During manipulation, 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/or separations. Some patients will feel stiffness and soreness following the first few days of treatment. Some techniques used to manipulate the cervical spine (neck region) have been implicated in injuries to arteries in the neck leading to, or contributing to, serious complications that include stroke. I have also indicated that with any procedure there is the possibility of an unexpected complication, though no guarantees or promises can be made concerning the results of any procedure or treatment.

The probability of those risks occurring: Fractures are rare occurrences and generally result from some underlying weakness of the bone. We screen for these risk factors during the history, examination and on x-rays (if x-rays are indicated). Manipulation induced stroke has been a subject of disagreement within and outside the profession. One prominent authority (Haldeman,DC,MD) states that there is, at most, a one-in-a-million chance of such an outcome. Since that risk should be avoided, we employ tests in our examination that are designed to identify whether you may be susceptible to such an injury. The other complications are also generally described as “rare”.

Treatment options other than chiropractic:

- Do nothing
- Self administered including over the counter analgesic and rest
- Medical care with prescription drugs such as anti-inflammatory, muscle relaxation and pain killers
- Surgery, Hospitalization, traction, rehabilitation

Risks inherent in other treatment options:

- The risk involved in doing nothing and remaining untreated. The formation of adhesions and loss of mobility sets up a pain pattern that may result in a chronic condition. Over time this may prolong treatment, make it more difficult and less effective.
- The risk in self administered treatment may result in overuse of over-the-counter medications which can produce undesirable side effects. If complete rest is impractical, premature return to work and other activities may aggravate the condition and extend the recovery time. The probability of such complications depends on the patient's general health, severity of discomfort, pain tolerance and self-discipline.
- The risk involved with medical care and prescription drugs. Undesirable side effects and dependence on drugs. The risk also depends on the patient's general health, severity of discomfort, pain tolerance, self discipline and medical supervision. Medications generally entail significant risks, some with higher probabilities.
- The risk involved in surgery. Adverse reaction to anesthesia, iatrogenic (doctor caused) mishap, risk of hospitalization (exposure to communicable disease, iatrogenic mishap and expense), and an extended convalescent period. The probability of those risks occurring varies according to many factors.

DO NOT SIGN UNTIL YOU HAVE READ AND FULLY UNDERSTAND THE CHIROPRACTIC TREATMENT INFORMED CONSENT

Please check the appropriate block and sign below;

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed with Dr. Ryan or Dr. Elise Hamilton and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing chiropractic treatment and understand that there are other treatment options. By signing below I state I have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the potential risks, I hereby give my consent to the aforementioned treatment.

Print Name:_____ Date:_____

Signature:_____

Signature of Parent/Guardian:_____