New Patient Intake Form

Patient Information

Today's Date: ____________________ Social Security #: ____________________ Birthday: ________________________

First Name: ____________________ Middle Name: ______________________ Last Name: ______________________

Sex: M F Preferred method of communication for patient reminders (Circle one): Email / Text

Home Phone: (_____)________________ Cell Phone: (_____)________________

Email: ____

Address: ____

City: ______________________ State: ___________________________ Zip Code: ________________________

Emergency Contact: __________________ Emergency Relation: _________________ Emergency Phone: ________________

How did you hear about us?: ____

Patient Health History

Health Conditions: ____

Surgeries, Hospital Stays: ____

Previous Chiro Care: Y N Explain: ____

Family Health History: ____

Health Checklist (*explain & list treatment if applicable*):

Arteriosclerosis	Spinal Curvature	Chest Pain	Diabetes
Back Pain	Swollen Joints	Pacemaker	Anemia
Bruise Easily	Ulcers	Stroke	Cancer
Cold Extremities	Constipation	Headaches	Arthritis
Dizziness	Loss of Senses	Swollen Ankles	Fatigue
Concussion	Loss of Balance	Stroke	Allergies
Shortness of Breath	Kidney Infection	Pregnant	

Other: ____

Patient Social

Alcohol:	Daily	Weekly	Occasion	Never	**Caffeine**:	Daily	Weekly	Occasion	Never
Stimulants:	Daily	Weekly	Occasion	Never	**Exercise**:	Daily	Weekly	Occasion	Never

Employment Information

Employed: Full Time Part Time Unemployed Student Employer: ______________________________

Occupation: ________________________ Work Duties: ____

Work Address: ____

Employer City: _____________________ Employer State: _____________ Employer Zip: ___________________________

Work Phone: (_____)________________

Current medications

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Cancellation / No Show Policy

Thank you for trusting your chiropractic and massage care to the Williamsburg Neck and Back Center (WNBC). When you schedule an appointment with WNBC, we set aside enough time to provide you with the highest quality care.

We understand that there are times when you must miss an appointment due to emergencies or other obligations. However, if you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

Should you need to cancel or reschedule an appointment, please contact our office at least 24 hours before your scheduled appointment, to avoid a thirty-five-dollar ($35) fee that will not be covered by your insurance company. *As a courtesy, WNBC provides patients with electronic reminders. If you do not receive a reminder text or e-mail, the above policy will remain in effect.*

Patient Signature: ____ **Date:** ______________

For office use only

Height: _______ Weight: _________ Blood Pressure: ___________

Informed Consent

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

The nature of the chiropractic adjustment: The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / examination / treatment: As part of the examination and treatment, you are consenting to the following:

- ☑ spinal manipulative therapy
- ☑ range of motion testing
- ☑ muscle strength testing
- ☑ therapeutic exercise
- ☑ palpation
- ☑ orthopedic testing
- ☑ reflex testing
- ☑ hot or cold pack therapy
- ☑ vital signs
- ☑ basic neurological testing
- ☑ interferential therapy
- ☑ massage therapy

The material risks inherent in chiropractic adjustments: As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I will make every reasonable effort during the examination to screen for contraindications to care, however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring: Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Strokes has been the subject of tremendous disagreement. The incidence of stroke is exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options: Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers
- Hospitalization and/or surgery

If you chose to use one of the above noted "the other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated: Remaining untreated may allow the formation of adhesions to reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to examination and treatment.

Dated: ____

Patient's Name: ____

Patient's Signature: ____

Signature of Parent/Guardian (if a minor): ____________________

Privacy Notice Summary

While the nature of a chiropractic practice requires that we gather personal financial and/or health information about you, we know that this information must be protected. The Williamsburg Neck and Back Center, LLC Privacy Notice applies to information gathered in connection with chiropractic services provided by the Williamsburg Neck and Back Center, LLC.

Information We Collect:

We get most information directly from you such as information provided to us on your patient information/insurance form, as well as medical information related to your treatment, either written or transcribed, by or for the physician. We also collect information about your insurance coverage including the company, your policy number, and benefits. We may obtain additional information from third parties. Third parties may include agents, employers, insurers, consumer reporting agencies, agencies of the Federal Government, or other health care providers. Information collected may relate to your finances, employment, health, treatment received, other personal information, as well as publicly available information about you.

Information We Disclose:

We may disclose collected information to other health care providers, insurers, consumer reporting agencies, research studies, attorneys, governmental agencies, affiliates, and non-affiliated service providers, when necessary to carry out our normal business activities. These activities may include: summary of treatment provided, recommended future treatment plans, information for evaluating and processing claims, and processing other transactions at your request. Service providers may include your physician and office staff who treat or assist in your treatment, as well as administrative personnel who process claims to be filed with your insurance company. We may also disclose collected information to law firms, consumer reporting agencies, or collection agencies with which we have an agreement. These non-affiliated companies are outside of the Williamsburg Neck and Back Center, LLC and may also include banks, other insurance companies, service vendors and insurance agencies. We also many disclose information as permitted or required by law. We do not disclose collected information about our former patients to anyone except as permitted by law.

Protection of Information:

Our employees are trained and required to maintain our privacy policies and procedures. Employees who violate those polices and procedures are subject to disciplinary action. Affiliates and third parties to whom we disclose information are required to maintain adequate security standards for the protection of collected information. In addition, we maintain physical, electronic and procedural safeguards to protect information. Federal and State laws require us to provide our Privacy Notice to you each year unless your relationship, as a patient, with the Williamsburg Neck and Back Center, LLC has terminated.

I acknowledge receipt of this summary of the Williamsburg Neck and Back Center, LLC Privacy Notice. I understand that a more detailed version of this Privacy Notice is available upon request.

Print Name:______________________________ Signature: __________________________ Date: __________________

Irrevocable Assignment of Benefits, Authorization and Lien

This Irrevocable Assignment of Benefits, Authorization and Lien (this "Assignment) is made by and between ___________________________("Patient") and Williamsburg Neck and Back Center, LLC ("Health Care Provider"). With this Assignment, and in consideration of treatment without having to render concurrent payment, Patient, hereby irrevocably transfers sets over and assigns to Health Care Provider all insurance and/or litigation proceeds to which Patient is now or may hereafter, become entitled, including those listed below, up to the total amount due and owing the Health Care Provider for services rendered to the Patient by reason of accident or illness, including interest thereon, as well as any other charges that are due or may become due the Health Care Provider, including, without limitation, requested reports, collection costs and expenses and attorney's fees, and Patient further hereby irrevocably authorizes and directs any insurance company and/or attorney to whom an original or copy of this Assignment is provided to withhold from Patient and pay directly to such Health Care Provider such amount(s) from (1) any insurance benefits payable to Patient or on Patients behalf, including, but not limited to, medical payments benefits, No Fault benefits, health and accident benefits, personal injury protection benefits, third-party liability coverage, foundation grants, governmental or agency benefits, worker's compensation benefits or any other insurance proceeds or benefits of any kind which are payable to or on behalf of the Patient, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgment or verdict in Patients favor as may be necessary to fully pay any and all financial obligations owed to the Health Care Provider by the Patient. This Assignment is to be a complete and current transfer of Patients right, title, and interest, separate from any statutory or contractual lien or claim to which the Health Care Provider may also be entitled. Patient acknowledges that Health Care Provider has a substantial pecuniary interest in the enforcement of this Assignment.

The Patient further agrees that, in the event the insurance company and/or attorney obligated hereunder to make payments to the Health Care Provider fails or refuses to may payment for the full amount due as set forth above, this Assignment is a full, immediate and complete assignment of all the Patient's rights, title, interest, remedies and benefits in and to the assigned property to the extent of the Health Care Providers total claim amount; therefore, Patient hereby irrevocably and fully assigns and transfers to the Health Care Provider any and all causes of action that Patient might have or that might exist in Patients favor against such insurance company and/or attorney with respect to the assigned property. In addition to the foregoing assignment, Patient hereby authorizes, nominates and appoints as Patients attorney-in-fact any officer of Health Care Provider, to prosecute said cause(s) of action either in Patients name or in the Health Care Providers name and Patient further authorizes the Health Care Provider to compromise, settle, or otherwise resolve said claim(s) or cause(s) of action as it sees fit.

In further consideration of the services provided by the Health Care Provider, Patient hereby grants a lien to said Health Care Provider against any and all insurance benefits and litigation proceeds outlined in the first paragraph above which may be payable to or on behalf of the Patient as a result of the injuries or illness for which Patient has been treated by said Health Care Provider. The Patient further agrees that the statute of limitations applicable to Health Care Providers right to demand payment from the patient shall be tolled for all reasonable times that negotiations or litigation between third parties and the Patient are ongoing.

Patient hereby acknowledges that Virginia law imposes a lien in the amount of $750.00 upon Patient claims against the individual or entity whose negligence is alleged to have caused Patients injuries.

Notwithstanding the foregoing, the Patient agrees that until the Health Care Provider is paid in full, the Patient shall remain personally and fully responsible for and promises to pay the total amount due the Health Care Provider (including principal, interest, collection costs and attorney's fees of 35%) until fully paid. The patient further understands and agrees that this Assignment does not constitute any agreement of or consideration for the Health Care Provider to await payments from any source, and in the event the Health Care Provider deems itself in its sole discretion insecure as to the prospect payment, it may demand payments from Patient immediately upon rendering services as its option and proceed to collect same through legal means if necessary.

Patient authorizes the Health Care Provider to release this Assignment and any information pertinent to Patients case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. Patient hereby nominates and appoints any officer of the Health Care Provider as Patient's attorney-in-fact to endorse/sign Patient's name on any and all checks for payment of the services provided to Patient by said Health Care Provider.

In the event that any part or provision of this Assignment shall be determined to be invalid or unenforceable, the remaining parts and provisions of this Assignment which can be separated from the invalid, unenforceable provisions shall continue in full force and effect.

Patient's Signature: ____ Date: ____________________

Printed Name: ____