Consultation Intake Form

Date:_____

Name: _____ Email Address: _____

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

Home Ph:_____ Work Ph: _____ Cell Ph: _____

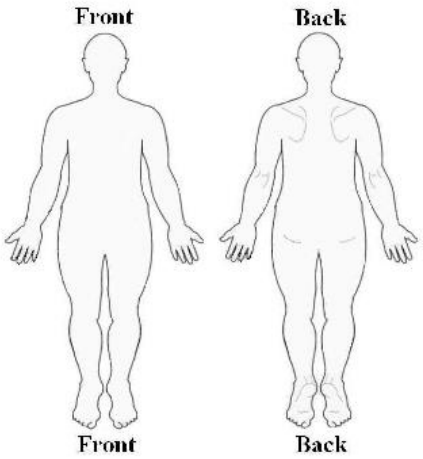
Birth Date: _____ Age: _____ Sex: M F single married partnered widowed divorced separated

Primary Care Physician _____ Social Security # _____

Occupation: _____ Employer:_____ # of hours worked per week: _____

Check any of the symptoms or conditions below that are currently have, or recently experienced:

__Headaches	__Carpal Tunnel	__ Knee Pain	__ Digestive Problems
__Neck Pain	__Vertigo	__Allergies	__Pain Between Shoulders
__Mid Back Pain	__Low Back Pain	__Loss of Balance	__Tension across Shoulders
__Sciatica Pain	__ Dizziness	__Menstrual Pain	__Numbness in Arms/Legs
__Leg or Hip Pain	__Shoulder/Arm Pain	__Low Energy/Fatigue	__ Other: _____



When did it begin? _____

_____

How long have you had the problem? _____

_____

What are your current symptoms? _____

_____

If you could get rid of one of these concerns, which would you choose? _____

How long you have you had it? _____ When it is at worst, how does it feel? _____

Have you been adjusted by a chiropractor before? _____ Yes _____ No If yes, Date of Last Adjustment?_____

Have you ever sought services for this or any other health concern from the following:

__Massage Therapist	__Acupuncturist	__Naturopath	__ Yoga Studio	__ Physical Therapist
__Personal Trainer	__Nutritionist	__Rolfer	__Pilates	__ Other: _____

Signature:_____ Date: _____

WALSH WELLNESS CENTER PATIENT REGISTRATION FORM

Today's Date:_____

PATIENT INFORMATION: (Please use full legal name, no nicknames)

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

*Address: _____

City: _____ State: _____ Zip: _____

Home Phone#: (_____)_____-_____ *Social Security #: _____

*Date of Birth:_____ Age: _____ *Sex: _____ Marital Status: _____ Drivers Lic#: _____

*Employer Name and Address: _____

_____ Work Phone#: (_____)_____-_____

E-mail Address:_____ Cell Phone #: (_____)_____-_____

Emergency Contact Name:_____ Emerg Phone#: (_____)_____-_____

Please tell us how you heard about us: _____ Referred by_____

GUARANTOR INFORMATION: (List person or insured name responsible for bill - use full legal name, no nicknames)

*Relationship of Guarantor to Patient: Self _____ Spouse_____ Parent_____ Other _____

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

*Address: _____

City: _____ State: _____ Zip: _____

Home Phone#: (_____)_____-_____ *Social Security #: _____

*Date of Birth:_____ Age: _____ *Sex: Female_____ Male _____

*Employer Name and Address: _____

_____ Work Phone#: (_____)_____-_____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards and Driver's License)

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INSURANCE:

Plan Name:_____ *Insured's Name: _____

Insured's Social Security#: _____ *Insured's Date of Birth: _____

*Policy / ID #:_____ *Group#:_____ Eff Date: _____

Claims Address & Phone: _____

SECONDARY INSURANCE:

Plan Name:_____ *Insured's Name: _____

*Insured's Social Security#:_____ *Insured's Date of Birth: _____

*Policy / ID #:_____ *Group#:_____ * Eff Date: _____

Claims Address & Phone: _____

*REQUIRED FIELDS-PLEASE COMPLETE FOR BILLING. *ATTACH COPY OF INSURANCE CARDS.

Please read and sign back of form.

PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

Patient Name: _____ Date of Birth: _____
First Name M.I. Last Name

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Walsh Wellness Center services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Walsh Wellness Center is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Walsh Wellness Center on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the Walsh Wellness Center Patient Information Privacy Policy. I authorize Walsh Wellness Center individually to release any of my or my dependent's medical or incidental or personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a Walsh Wellness Center representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind authorization at any time by notifying Walsh Wellness Center to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my Walsh Wellness Center physician or his or her designee.

PATIENT SIGNATURE: _____ DATE: _____

GUARANTOR SIGNATURE: _____ DATE: _____
(If different from patient)

GUARANTOR NAME (Please Print): _____

CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Signature_____ Date _____

Witness Signature _____ Date_____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

You may file a written complaint to the Secretary of Health and Human Services if you believe your privacy rights with respect to confidential information in your medical records have been violated. If you're not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to: DDHS. Office of Civil Rights, 200 Independence Ave, S.W. Room 509F HHH Building, Washington, DC 20201.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- I give my permission to **WALSH Wellness Center** to use my address, phone number and clinical information to contact me, and/or other physicians, and/or my employer (if work related) with appointment changes, follow-up messages, test results, laboratory results, and/or, other related health information.
- The practice reserves the right to change the privacy policy as allowed by law.
- All requests for inspection, copying and/or amending information in your medical records must be made in writing and be addressed to Dr. Patrick Walsh at our address.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.
- We may contact you by phone, text message, or leave a voice message on your home or cellular phone regarding appointments.

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

ASSIGNMENT, LIEN AND AUTHORIZATION

INSURANCE BENEFITS AND ATTORNEY

To Whom It May Concern,

I hereby authorize and direct you, the insurance company and /or my attorney , to pay directly to Walsh Wellness Center (hereunder described as "The Clinic") such sums as may be due and owing The Clinic for services rendered to me, both by and reason of accident, of illness and by reason of any other bills that are due The Clinic, and to withhold such sums from any disability benefits, medical payment benefits, or any other insurance benefits obligated to reimburse me from any settlement , judgment or verdict on behalf as may be necessary to adequately protect The Clinic. I hereby further give a Lien to The Clinic on any and all insurance benefits named herein, and on any and all settlements, judgments or verdicts which I have been treated by The Clinic. This is to act as an Assignment of my rights and benefits to the extent of the services, supplements, supports and any equipment of any kind provided by The Clinic.

I understand that I remain personally responsible for the total amounts due The Clinic for all services and goods it has rendered and given. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for The Clinic to await payments and that The Clinic may demand payments from me immediately upon rendering services or providing related goods such as The Clinic deems appropriate.

I authorize The Clinic to release any information pertinent to my case to any insurance company, managed car organization, attorney or adjuster to facilitate collection under the Assignment, Lien and Authorization. I agree that The Clinic be given power of Attorney to endorse/sign my name on any and all checks for payment of The Clinic's bills. I further understand and agree that if The Clinic must take action to collect any outstanding balances on my account, I will be held responsible for payment of them and will reimburse The Clinic for all costs incurred by such collection efforts including but not limited to all court costs and all attorney fees.

Date: _____

Patient/Guardian Signature: _____

Witness: _____