Dr. Michael T. Kelly D.C. P.A

NEW PATIENT INTAKE FORM

Patient Information

First Name_____ Middle _____Last _____

Date of Birth _____ SEX: M F Married Single Other

Address _____ City _____ State_____ Zip_____

Home Phone _____ Cell Phone_____

Work Phone_____ Email_____

Occupation_____ Employer's Name_____

Emergency Contact_____ Phone_____

How did you hear about Hands on Performance? _____

Insurance Information

Do you have insurance which covers chiropractic treatment: YES NO

Insurance Company _____

Plan ID# _____ Group# _____

Claim Number_____

Primary inured same as patient: YES NO

Patient Relationship to Insured: Self Spouse Child Other

Accident/Illness Information

Is this condition related to:

Employment	YES	NO
Auto Accident	YES	NO
Other Accident	YES	NO

Date of Accident _____ /_____ /_____

Location/State of Accident _____

Attorney Name: _____

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PRESENTING PROBLEM

What is the presenting issue? _____

When did this issue begin? _____

What was the cause of the injury? _____

Where is the pain located? _____

Describe the pain (aching, burning, sharp, ect): _____

Rate this pain 0-10 as it is now, 10 being the most painful: _____

Does anything alleviate the pain? _____

Does anything worsen the pain? _____

Does the pain radiate into the extremities? _____

Is the pain worse at a certain time of day? If so, when? _____

Are there any other associated symptoms? _____

_____

Does the pain affect any of your daily activities? If so, please explain. _____

_____

Have you been treated for this issue before? If so, by who & what was the treatment? _____

_____

Has there been any imaging performed for this issue? If so, what kind? (X-Ray, MRI, CT, ect): _____

_____

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HISTORY

Patient Name: _____ Date: _____

Height: _____ Weight: _____

Have you ever been diagnosed with any disease(s)? _____
If yes, please list all, including from childhood: _____

_____

Please list any surgeries, illnesses or major traumas (ie: concussion, broken bone, ect):_____

_____

Have you ever been diagnosed with a compression fracture, Spondylolisthesis or any other spinal injuries? Please list here: _____

_____

List any/all allergies: _____

_____

List any/all medications you are currently on or have taken recently: _____

_____

_____

List any/all vitamins or supplements you are currently taking or have taken recently: _____

_____

_____

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Have any relatives suffered from diseases such as Heart Disease, Diabetes, Cancer or any other inherited disease? If so, please list here: _____

_____

Have you been treated by a chiropractor before? If yes, please explain (when, why, where): _____

_____

YES NO Do you feel fatigued on a regular basis?

YES NO Do you have difficulties sleeping soundly through the night?

YES NO Do you drink water on a regular basis? How many glasses a day? _____

YES NO Are you currently taking any NSAIDS (Ibuprofen, Acetaminophen, Naproxen, ect)

If yes, what dose & how often? _____

Rate your stress level: LOW MEDIUM HIGH

Alcohol Intake: ☐ Currently ☐ Past ☐ Never

Drinks/week: _____

Smoking/Tobacco Use: ☐ Currently ☐ Past ☐ Never

Type/How often: _____

Recreational Drug Use: ☐ Currently ☐ Past ☐ Never

Type/How often: _____

How often do you exercise? ☐ Never/Rarely ☐ 1-2x/week ☐ 3-5x/week ☐ 6+/week

Type of exercise: _____

_____

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NEW PATIENT – INITIAL EXAM

Patient Name: _____ Date: _____

Chief Complaint: _____

Insurance: _____

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Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustment and other chiropractic procedures including various modes of physical therapy and, if necessary, diagnostic x-ray on myself, or the patient named for whom I am responsible, _____ by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the physician at **Hands On Performance** and/or other licensed chiropractic physicians who may treat me now or in the future at this office. I have had an opportunity to discuss with **Dr. Michael T. Kelly** and/or with other office personnel 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 and all healthcare, the practice of chiropractic carries some risks to treatment including, but not limited to: fractures, disc injuries, strokes (CVA), dislocation and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

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

To be completed by Patient:

_____
Print Patient's Name

_____
Signature of Patient

_____
Date

To be completed by the patient's representative if necessary (patient is a minor or is physically or mentally incapacitated):

_____
Print Name of Representative

_____
Signature of Representative

_____
Date

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TO ALL PATIENTS:

Effective February 1, 2014

Your medical insurance policy is a contract between you, the patient, and your insurance company.

Verification of insurance coverage is not a guarantee of insurance benefits. Your coverage and benefit payments are determined when a claim is received.

This office and Dr. Kelly are participating providers with most major medical insurance companies and, as a courtesy to you, we will file your insurance for reimbursement with your insurance company.

However, with the new health care laws taking effect as of January 2014, and the noncompliance, third party interventions and continual denials by the insurance companies, this office will not continue to re-file denied claims to be paid.

After the first filing, all other correspondence with your insurance company will be the patient's responsibility. We will be happy to assist the patient by providing you with all the necessary documentation to receive your reimbursement.

I have received and understand the notice to all patients regarding the new health insurance submission policies. As of February 1, 2014, Hands On Performance, office of Dr. Michael T. Kelly, will only submit you claim once per visit.

_____

Print Name

_____ _____/_____/_____

Signature Date

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Assignment and Authorization

For good and valuable consideration, including the agreement of MICHAEL T. KELLY D.C P.A. to accept this agreement in lieu of demanding full payment for service from the undersigned of date each service is rendered, the undersigned patient executes this document hereby assigning to MICHAEL T. KELLY D.C. P.A. the right to receive insurance benefit, to me or on my behalf, for service rendered by MICHAEL T. KELLY D.C. P.A.

Any insurance company that may be obligated to provide insurance benefits, to me or on my behalf, for the services provided by MICHAEL T. KELLY D.C. P.A.is hereby directed to issue payment for those benefits directly to and payable to MICHAEL T. KELLY D.C. P.A.

I also authorize and assign to MICHAEL T. KELLY D.C. P.A. the right the file suit and pursue all legal remedies to obtain payment for service provided to be by MICHAEL T. KELLY D.C. P.A. This authorization to file suit is assignment of my cause of action to obtain payment for service provided to be by MICHAEL T. KELLY D.C. P.A. and include the assignment to pursue all legal remedies against the insurer.

Please read this document before signing. If you do not completely understand this document or have any questions about it's contents, please ask an office member to explain it to you. If there is any portion of this document that you do not wish to authorize, we will remove that portion from this document. Your signature below is your agreement that you fully understand this document and you fully agree to the terms of this document.

_____ _____ /_____ /_____
Patients Signature Date

_____ _____ /_____ /_____
Witness Signature Date

_____ _____ /_____ /_____
Authorized Signatory for Medical Provider Date

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NOTICE OF PRIVACY PRACTICE RECEIPT ACKNOWLEDGMENT

I acknowledge that I was provided a copy of the Notice of Privacy Practices, that I have read them or have declined the opportunity to read them, and I understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____

Print Patient Name

_____

Parent, Guardian or Patient's Legal Representative

_____

Signature

_____

Date

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