- Individualized Family Chiropractic Care
- Customized Nutritional Counseling
- Pediatric & Perinatal Certified
- Rehabilitation Exercises

# NUTRITION COACHING NEW PATIENT INFORMATION FORM

Name _____ Date _____

Address _____ Apt.#_____

City _____ State _____ ZIP _____

Shipping Address (if different) _____

Cell Phone (____) ____-_____ Work Phone (____) ____-_____

E-mail address: _____

Name of Individual with whom you authorize us to share your health information/appointment scheduling/financial information:_____

**REFERRED BY:** _____

Occupation _____ Employer _____

Date of Birth _____ Age ____ Sex: M/F Height _____ Weight _____

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

Chief complaint (reason you are here): (use separate sheet if more room needed)

_____

_____

_____

_____

_____

Previous treatments for this complaint _____

_____

Other complaints or problems: (use back if needed) _____

_____

Current medications/drugs being taken: (use separate sheet if needed) _____

_____

Are you currently under the care of a physician or other health care professionals?

(If yes, please give name and date of last visit):

_____

Nutritional supplements you are taking: _____

How much of the following do you consume per day?

Cigarettes (packs) _____ Coffee (cups) _____ Alcohol (glasses)_____Water (glasses) _____

1. **Dietary Intake for 2 days before appointment:**

| | |
|---|---|
| **Breakfast:** | **Breakfast:** |
| **Lunch:** | **Lunch:** |
| **Dinner:** | **Dinner:** |
| **Snacks:** | **Snacks:** |

## PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: □ Appendectomy □ Tonsillectomy □ Gall Bladder □ Hernia □ Back Surgery □ Broken Bones

□ Other (please list details)_____

Major Accidents Or Falls: _____

Hospitalization (Other Than Above): _____
Previous Chiropractic Care: □ None □ Doctor's Name & Approximate Date of Last Visit: _____
Date of Last: Spinal X-ray _____MRI _____(region:_____) Physical Exam:_____

Below is a list of diseases, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect you overall course of care.

### CHECK ANY OF THE FOLLOWING DISEASES or SYMPTOMS YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer (type: _____)
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

### CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST SIX MONTHS:

**MUSCULO-SKELETAL**

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness
- ☐ Gas/Bloating After Meals
- ☐ Heartburn/Reflux
- ☐ Black/Bloody Stool
- ☐ Irritable Bowel/Colitis/Chron's

**NERVOUS SYSTEM**

- ☐ Weakness in arms/legs/body
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Cold or discolored extremities
- ☐ Fainting
- ☐ Convulsions or Seizures
- ☐ Tingling Extremities

**GENITO-URINARY**

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine
- ☐ Kidney Stones

**C-V-R**

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems or congenital defect
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

**EENT**

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches or Infection
- ☐ Hearing Difficulty
- ☐ Stuffed Nose or Sinus Infection
- ☐ Ringing in the ears

**FEMALES ONLY**

When was your last period?

_____

Are you Pregnant?

☐ Yes ☐ No

**MENTAL/EMOTIONAL**

- ☐ Anxiety
- ☐ Psychotic episodes
- ☐ Attempted suicide in lifetime
- ☐ Anger/aggression
- ☐ Attention Deficit
- ☐ Depression

**MALE/FEMALE**

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems

**GENERAL**

- ☐ Fatigue
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches
- ☐ Allergies: List: _____

**GASTRO-INTESTINAL**

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

**FAMILY HISTORY**

List family members with the following illnesses:

- ☐ Heart Disease _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Stroke _____
- ☐ Neurological Disorder _____
- ☐ Other _____

**EXERCISE**

- ☐ None
- ☐ Mild 1-2x/wk
- ☐ Moderate 3x/wk
- ☐ Daily
- ☐ Heavy (daily and intense)

**HABITS**

- ☐ High Stress Level
  Reason _____
- ☐ Things you do to handle stress
  _____
  _____

==========

Marital Status: S M D W Name of Spouse _____

Describe health of spouse: _____ Number of children if any _____

| Name of Child | Age | Sex | Any physical conditions or concerns? |
|---|---|---|---|
| _____ | _____ | M/F | _____ |
| _____ | _____ | M/F | _____ |
| _____ | _____ | M/F | _____ |

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other _____

Any household pets or other animals you or family members are in close contact with:

_____

What can we do to make you happier? _____

_____

SIGNED: _____ DATE _____

# CREDIT CARD PREAUTHORIZATION

Healthcare Complete
260 Merrimac Street-The Towle Building
Newburyport, MA 01950
978-499-WELL (9355)

To better serve our patients, and to give the best care to everyone, we are requiring a credit/debit card to be kept confidentially in each individual's file. Please complete the information below:

Patient Name: _____

I authorize Healthcare Complete to charge my credit card account for patient care under the following circumstances (check off each one that you authorize):

- ☐ Please charge my credit card weekly in pre-payment of my appointments
- ☐ Please charge my credit card after each visit
- ☐ My bill is over 90 days past due, and an attempt to reach me by phone or mail has been made, without response.
- ☐ My insurance didn't cover a service I received, and an attempt to reach me by phone or mail has been made, without response.

Patient Signature _____ Date_____

OUR MISSION

## To create optimal lifelong health and well-being for families, from newborns to seniors, by caring for the unique needs of the whole person and educating our community about the body's natural ability to heal.

This office is committed to providing patients with quality health care services delivered with dignity and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patient working together as a team to obtain the maximum results. Patient satisfaction is a vital interest to our staff.

Please direct any questions or concerns to a member of our staff. We encourage questions and/or concerns to avoid misunderstandings. Office hours allow our patients convenience to schedule appointments before and after work as well as during lunch. If you must miss an appointment, please notify us. If you do not show up for your scheduled appointment you will be charged $25.00 as a missed appointment fee that you must pay before you are seen or treated again. We are available to immediately see new patients the same day. As a courtesy for you, we may call you on the telephone when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call you or mail you reminder cards, please let us know in writing in. Patients are encouraged to leave valuables at home or with an accompanying family member or friend. This facility shall not be liable for the loss of or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents or any other items.

### HEALTHCARE PRIVACY NOTICE/HIPPA

I acknowledge that I have received a copy of the Notice of Privacy Practices for Protected Health Information of Healthcare Complete.

____(Initial) I authorize that this office may share my health information, appointment and financial arrangements with: (List person(s)) _____

### INFORMED CONSENT/NO GUARANTEE POLICY

I understand that this facility, its doctors & staff are accepting my case based on examination findings & believe the outlined treatment should produce change and/or improvement. However, as with any diagnostic test procedure, examination, or doctor's care, a guarantee or promise of improvement or complete recovery cannot be made and it is even possible that no change will occur. I further understand that in the practice of chiropractic, massage therapy, rehabilitation, and nutrition counseling there are some risks including but not limited to fracture, disk injury, stroke, dislocation, sprains-strain, and/or side effects which cannot be predetermined. I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of procedure(s) which the doctor/provider feels at the time is in my best interest. In addition, because the psycho-social., spiritual, and cultural values affect a patient's response to care, patient's are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment.

I understand that I have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with the prescribed treatment your provider will discuss the associated risks. The patient agrees to be compliant with the agreed upon treatment recommendations and treatment schedules and to maintain open communication with the doctor in regards to any misunderstandings involved with their care in the office. The Patient understands that lack of cooperation, failure to keep appointments; failure to follow exercise and other recommendations, engaging in activities identified by the Office as potentially injurious or traumatic to the body may necessitate additional treatments and therefore result in additional costs.

I may discontinue care and terminate the care plan at any time by written notice to that effect delivered in person, by fax, or by mail, to the Office. Such "notice of termination" shall discharge the Office from all further obligations and/or duty to render care.

The care the Patient is to receive will be outlined in a treatment plan and will be determined based upon the Patient's present condition. If a new injury or condition arises during the course of treatment provided for hereby, then, and in that event, care to be provided under the current treatment plan will be suspended until such time as the subsequent problem has resolved, or maximum medical improvement has been obtained. In the event that there is some type of insurance coverage available for the subsequent event such as a Worker's Compensation, Homeowner's, Automobile Medical- Payments or other insurance benefits relating to personal injury, then, and in that event, the Office shall have the option to bill said insurances for the care related to the subsequent injury or condition.

### ASSIGNMENT OF BENEFITS/AUTHORIZATION & LIEN

I, the assignee, being the patient or the legal guardian for said minor listed below, do hereby irrevocably authorize, direct, assign and give a full lien to the office named above and listed below, hereinafter referred to as the "Facility" against any & all insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the Facility.

I, the assignee, further authorizes any and all insurance company(s), attorney, and any third party payer to pay the Facility all sums of money due them for any & all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or third party benefits.

Assignee agrees that this facility & staff may deliver medical records, consultations, depositions, and/or court appearances which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care to any insurance company, adjuster, attorney, or legal service bureau to facilitate collections under the terms of this document. Assignee grants this Facility a full power of attorney to endorse any checks for payments to this office for any indebtedness owed to this office for services rendered to the patient.

### INSURANCE BENEFITS/CREDIT POLICIES/DISCOUNTS/PAYMENT TERMS/REFUND TERMS

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us, but some third party payers misquote benefits, coverage, and liability. Our Facility & staff are not responsible for what a third party payer and/or a representative may tell us. Any contractual, written, verbal, or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person. Our Facility will file initial insurance claims for you.

Co pays, deductibles, and all non-covered service charges are due the day the service is rendered. For your convenience we accept cash, check, debit and credit cards. For patients who have insurance plans for which we are out-of-network, you are responsible for charges on all service(s) and/or product(s) which insurance reimbursement is lower than our billed amount.

All account balances, including automobile and or work injury claims must be paid in full within 90 days of the release of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover the said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90 day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this Facility for any and all treatment, products, and services rendered to the patient or minor shown below. This office requires a credit card to be kept in our secure files. If charges are over 90 days past due or in the unlikely event insurance does not cover services rendered, Healthcare Complete will contact the assignee to utilize the credit card on file to pay for balances owed.

A non-discriminatory "Time of Service Discount" is offered to anyone who pays for services the day they are rendered or before they are rendered. The "TOS" is only offered on the day of service or before the day of service. This discount does not apply to supports, orthotics, physical therapy equipment, supplements or other retail items.

A service charge is computed by a "periodic rate" of 1.5 % per month-18% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, costs related to but not limited to all collections related expenses, attorney fees, court & filing fee's. Returned checks, debits & credit charges made payable to this Facility for insufficient funds, stop payments, or other of non-payment will be assessed a $30.00 charge.

If a patient decides to terminate a pre-paid care plan prior to the termination date or visit limit, the patient shall be entitled to a refund. The refund shall equal the lump-sum amount(s) paid less any and all sums due for the services actually performed, including adjustments or other treatments, and examinations, re-examinations and consultations. Refund requests must be made in writing to the office and funds will be paid to the patient within 30 days of the termination by either party.

Your signature on this document fully authorizes our staff & doctors to perform any examinations, diagnostic tests &/or treatment as we may consider medically necessary & to release all information pertinent to your health, insurance or benefits to any & all applicable parties on your behalf. Your signature on this document confirms that you have read, understand and agree to comply with all of the terms & conditions of the Health Care Privacy Notice and all policies, consents, terms & conditions regarding your responsibilities to this Facility and that you grant the physicians, therapists and/or staff of this Facility to use and share your confidential health information with others in order to treat you and/or to arrange for payment of your bill and/or for issues that concern this Facility operations and responsibilities.

Patient Signature: _____ Printed Name: _____ Date: _____

Doctor Signature: _____ Printed Name: _____ Date: _____