CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your photo ID and insurance card(s). All information you supply is confidential.

INITIAL INTAKE FORM

Today's Date (MM/DD/YYYY) __________

Patient Number (office use only) __________

Whom may we thank for referring you? __________

Birth Date (MM/DD/YYYY) __________

Age __________

Gender
◯ Male ◯ Female

Your Last Name __________

Your Social Security Number __________

Your First Name __________

Your Middle Name (of Initial) __________

Address __________

City __________

State __________

Zip Code __________

Home Phone __________

Cell Phone __________

Email Address __________

Cell Carrier __________

Emergency Contact Name & Phone Number __________

Your Occupation __________

Your Employer __________

Primary Care Provider's Name and Phone Number __________

Insured's First and Last Name __________

Insured's DOB __________

Insurance Carrier __________

Policy Number __________

Address & Phone Number __________

Smoking Status (age 13 and over)
◯ Never ◯ Former
◯ Current Daily ◯ Occasional
◯ Heavy ◯ Light

Marital Status ◯ Married
◯ Single ◯ Divorced
◯ Widowed ◯ Separated

Preferred Language __________

Spouse's Name __________

Child's Name and Age __________

Child's Name and Age __________

Child's Name and Age __________

Work Phone __________

May we contact you at work?
◯ Yes ◯ No

Preferred method of Contact?
◯ Home Phone ◯ Cell Phone
◯ Work Phone ◯ Email
◯ Text Messages

Patient (or Guardian's) signature __________

Date (MM/DD/YYYY) __________

Patient Name ______________ Patient Number ______________ (office use only)

Please describe your Primary Complain in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint
The primary symptom that prompted me to seek care today is: ______________

And are the result of:
◯ An accident or injury
◯ Work ◯ Auto ◯ Other________
◯ A worsening long-term problem
◯ An interest in: ◯Wellness
◯ Other ______________

Onset (When did you first notice your current symptoms?) ______________

Prior interventions (What have you done to relieve the symptoms?)
◯ Prescription medication ◯Acupuncture
◯ Over the counter drugs ◯ Chiropractic
◯ Homeopathic remedies ◯ Massage
◯ Physical therapy ◯ Ice
◯ Surgery ◯ Heat
◯ Other ______________

Check any activities which aggravate this:
◯ Standing ◯ Lying down
◯ Bending ◯ Coughing
◯ Twisting ◯ Walking
◯ Sitting ◯ Lifting

Secondary Complaint
The secondary symptom that prompted me to seek care today is: ______________

And are the result of:
◯ An accident or injury
◯ Work ◯ Auto ◯ Other________
◯ A worsening long-term problem
◯ An interest in: ◯Wellness
◯ Other ______________

Onset (When did you first notice your current symptoms?) ______________

Prior interventions (What have you done to relieve the symptoms?)
◯ Prescription medication ◯Acupuncture
◯ Over the counter drugs ◯ Chiropractic
◯ Homeopathic remedies ◯ Massage
◯ Physical therapy ◯ Ice
◯ Surgery ◯ Heat
◯ Other ______________

Check any activities which aggravate this:
◯ Standing ◯ Lying down
◯ Bending ◯ Coughing
◯ Twisting ◯ Walking
◯ Sitting ◯ Lifting

Additional Complaint
The additional symptom that prompted me to seek care today is: ______________

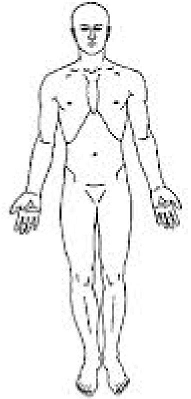
And are the result of:
◯ An accident or injury
◯ Work ◯ Auto ◯ Other________
◯ A worsening long-term problem
◯ An interest in: ◯Wellness
◯ Other ______________

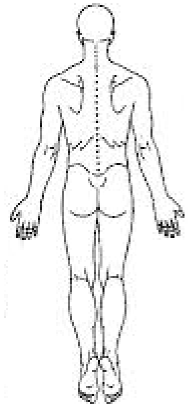
Onset (When did you first notice your current symptoms?) ______________

Prior interventions (What have you done to relieve the symptoms?)
◯ Prescription medication ◯Acupuncture
◯ Over the counter drugs ◯ Chiropractic
◯ Homeopathic remedies ◯ Massage
◯ Physical therapy ◯ Ice
◯ Surgery ◯ Heat
◯ Other ______________

Check any activities which aggravate this:
◯ Standing ◯ Lying down
◯ Bending ◯ Coughing
◯ Twisting ◯ Walking
◯ Sitting ◯ Lifting

Location
(Where does that hurt?) Circle the area(s) on the illustration.





1. What else should Dr. Enos know about your current condition? ______________

2. How does your current condition interfere with your:
Work or career: ______________
Recreational activities: ______________
Household responsibilities: ______________
Personal relationships: ______________

3. List all prescription drugs you now take: ______________

4. List all prescription non-drugs you now take: ______________

5. List all previous accidents: ______________

6. Have you had any X-Rays/MRIs/CTs/etc? Where and When? ______________

7. Have you ever been adjusted by a Chiropractor before? ◯ YES ◯ NO
Reason for those visits: ______________
Doctor's Name: ______________
Approximate Date of Last Visit: ______________

Check here if you have a family history of:
◯ Arthritis
◯ Diabetes
◯ Cancer
◯ Cardiovascular Disease

Please check the type of care desired so that we may be guided by your wishes when possible:
◯ Temporary Relief ◯ Control of immediate pain ◯ Total healthcare ◯ I prefer the Dr. to select the type of care he feels is best for me

____
Patient (or Guardian's) signature

____
Date (MM/DD/YYYY)

12 Calef Street
Warwick, RI
02886

BLANKET AUTHORIZATION/RELEASE FORM

Initials _____ I authorize payment of medical benefits from _______________Insurance Company to be paid directly to: Jamie M. Enos, D.C. for services rendered to me. If my current policy prohibits the direct payment to Enos Chiropractic Center, and I as the subscriber receive a check from my insurance company that is intended for this practice for services rendered, I must immediately remit this to our office for credit to my account. I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive. I agree to pay any balance that remains after my insurance company has made payment, and any unpaid balance that remains 60 days after services are rendered. I hereby direct all payers to release to ENOS CHIROPRACTIC CENTER any information regarding coverage or benefits which I may have including, but not limited to, the amount of coverage, the amount paid thus far, and the amount of any outstanding claims.

Initials _____ I do not have insurance benefits available and agree to pay for all services rendered to me, at the time they incur, unless otherwise agreed to in the form of a financial payment contract.

Initials _____ I understand that I am ultimately responsible for payment in full and agree to pay a $10 per month billing charge and a 1.25% monthly interest charge for all unpaid balances, which become 30 days past due. If necessary, I also agree to take full responsibility for all third party costs, including collection agencies, reasonable attorney fees and/or court costs incurred in attempting to collect this debt

Initials _____ I hereby authorize the release of my x-rays and medical records from any medical provider, hospital, attorney or insurance company upon receipt of a copy of this form, to ENOS CHIROPRACTIC CENTER.

Initials _____ To the best of my knowledge I am not pregnant. I understand that x-ray radiation may pose risks to an unborn child. I consent having x-rays taken, and I release Dr. Jamie Enos, and the office from any responsibility that could in any way associate damage to an unborn child with the x-ray examination. If you have any concerns, please consult the doctor.

Initials _____ I instruct Dr. Enos to deliver the care that, in his professional judgment, can best help in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials _____ I hereby acknowledge and understand that if I do not keep appointments as recommended by my attending chiropractor, I cannot expect maximum chiropractic results and the doctor has full and complete right to terminate my case and discharge me from care.

Initials _____ I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending doctor and it is the responsibility of the staff to carry out the instructions of such doctor.

Initials _____ I grant permission to be called, texted and/or emailed to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office..

Initials _____ I hereby give my consent for Dr. Jamie Enos to examine and render treatment to my son/daughter ____ who is a minor.

Initials _____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

I have read the above blanket authorization/release form and agree to the initialed items.

_______________________________________ _______________________________________

Patient Name (print) Patient /Guardian Signature

Date:_________________ ECC Witness: ___________________________________

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AUTO ACCIDENT QUESTIONAIRE

1. What was the date of the accident? ______________________________
2. What time did the accident occur? ______________________________
3. How many vehicles were involved in the accident? ______________________________
4. What was the estimated damage to the vehicle you were in? ______________________________
5. What state did the accident occur in? ______________________________
6. What city did the accident occur in? ______________________________
7. What street or intersection were you on when the accident occurred? ______________________________
8. What direction were you traveling in? ______________________________
9. What type of impact was the auto accident? ______________________________
10. Did your vehicle hit anything after the incident? If yes, please describe. ______________________________
11. Where were you sitting in the vehicle during the accident? ______________________________
12. Did you know the accident was coming? ______________________________
13. What type of vehicle were you in? ______________________________
14. What type of vehicle impacted yours? ______________________________
15. At the time of impact, how fast was your vehicle moving? ______________________________
16. At the time of impact, how fast as the other vehicle moving? ______________________________
17. During and after the crash, what happened to your vehicle? (check all that apply)
    ◯ kept going straight ◯ spun around ◯ spun around and hit a stationary object
    ◯ hit a car in front of yours ◯ hit by another vehicle ◯ hit stationary object
18. Did you lose consciousness during the accident? ◯ yes ◯ no
19. How was your head positioned during the accident? ______________________________
20. How as your torso positioned during the accident? ______________________________
21. How were your hands positioned during the accident? ______________________________
22. Did your head hit anything during the accident? ◯ no ◯ yes, please describe ______________
23. Did your face hit anything during the accident? ◯ no ◯ yes, please describe ______________
24. Did your shoulders hit anything during the accident? ◯ no ◯ yes, please describe ______________
25. Did your neck hit anything during the accident? ◯ no ◯ yes, please describe ______________
26. Did your chest hit anything during the accident? ◯ no ◯ yes, please describe ______________
27. Did your hips hit anything during the accident? ◯ no ◯ yes, please describe ______________
28. Did your knees hit anything during the accident? ◯ no ◯ yes, please describe ______________
29. Did your feet hit anything during the accident? ◯ no ◯ yes, please describe ______________

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30. What kind of headrest was in your vehicle?
    ◯ movable fixed ◯ non-movable fixed ◯ no headrest
31. Where was the headrest positioned at your head? ______________________________
32. Did you have your seatbelt on during the accident? ◯ yes ◯ no
33. Did you slide out of your seatbelt during the accident? ◯ yes ◯ no
34. What was damaged in your vehicle? (check all that apply)
    ◯ windshield ◯ rear bumper ◯ mirror ◯ steering wheel ◯ front bumper ◯ knee bolster
    ◯ dashboard ◯ trunk ◯ back right door ◯ back left door ◯ front left door ◯ front right door
    ◯ side window ◯ rear window ◯ seat frame ◯ completely totaled
35. Choose the items that dented inward:
    ◯ floorboards ◯ side door ◯ dashboard
36. Choose the doors that would not open as a result of the accident:
    ◯ front left ◯ front right ◯ rear left ◯ rear right
37. Did you go to the hospital? If no, why and do not answer #s 38-43 ______________________
38. How did you get to the hospital? ______________________________
39. What was the name of the hospital? ______________________________
40. Were you hospitalized overnight? ______________________________
41. Where you prescribed anything at the hospital? (check all that apply)
    ◯ pain medication ◯ muscle relaxers ◯ neck brace ◯ other: ______________
42. Did you receive any stitches for any cuts at the hospital? ◯ no ◯ yes, please describe ____________
43. Were any X-Rays/CT scans/MRIs taken at the hospital? ◯ no ◯ yes, please describe ____________
44. Since the accident, how have you been feeling? (check only one)
    ◯ getting worse since the accident ◯ getting better since the accident
    ◯ not getting worse or better since the accident

______________________________ ______________
Patient (or Guardian's) signature **Date (MM/DD/YYYY)**

NOTES: (office use only)

12 Calef Street
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OFFICE POLICY FOR WORKERS COMPENSATION, AUTO ACCIDENT and PERSONAL INJURY

We have developed this information to make you aware of our billing policies at the time of your initial office visit. Please review these policies carefully. By signing the form, you are agreeing to abide by the terms of our office policies and procedures.

Chiropractic services are reimbursed under the provisions of most health insurance policies. Our office personnel is familiar with the various coverage offered by health insurance companies; but you as the subscriber are primarily responsible for knowing the terms of your policy. Your insurance co-payments are payable at the time of services rendered.

Liability cases are accepted: however your auto insurance with a med-pay plan will be initially utilized. We require your health insurance on file at the start of your treatment. If your claims are denied for any reason, they are automatically turned over to your health insurance for processing. It is your responsibility to provide us with updated information should your health insurance change. Any deductible, co-pay, co-insurance or unpaid remaining balance from your health insurance is your responsibility. We will accept the health insurance plan's allowable, along with the co-pays and/or deductibles as payment in full for any covered services rendered to our patients.

If my current insurance policy prohibits the direct payment to Enos Chiropractic Center, and you as the subscriber receive a check from your insurance company that is intended for this practice for services rendered, you must immediately remit this to our office for credit to your account

Worker's Compensation patients will be accepted according to the new Worker's Compensation Law. Should your claim be denied by the RI Worker's Compensation Court, you will be responsible for providing us with your third party insurance so that chiropractic services rendered to you can be submitted for payment of your account.

Please note that you are responsible for payment of services you receive at Enos Chiropractic Center. We will do our best to assist in gathering the information regarding your insurance coverage, but it is your responsibility to know your benefit and coverage limitations.

Motor Vehicle Accident Billing Only:

I am using my MedPay on my car insurance, ______________________ for claims. Initial _______

I have no or my MedPay on my car insurance plan has been exhausted nor do I have an attorney for my AA. Please bill my health insurance, ____________________________, for claims. Initial _______

By signing below, I have read, understood, and accepted the policies stated above.

_______________________________________ _______________________________

Signature Date Signed

12 Calef Street
Warwick, RI
02886

DOCTOR'S LIEN

Patient Name:____________________________________

Date of Injury:__________________

I do hereby authorize **Enos Chiropractic Center**, to furnish you, my attorney, with a full report of their examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved. I hereby authorize and direct you, my attorney, to pay directly to said doctors such sums as may be due and owing him/her for medical service rendered me by reason of this accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctors. And I hereby further give a lien on my case to said doctors against any and all proceeds of my settlement, as the result of the injuries for which I have been treated of injuries in the connection therewith.

I fully understand that I am directly responsible to said doctor for all medical bills submitted by him/her for service rendered me and that this agreement is made solely for said doctors' additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fees.

____ ________________________

Patient/Guardian/ Signature **Date**

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctors above named. In addition, in the event that said patient terminates business with this attorney, attorney will notify said doctors immediately in order for doctors to make other arrangements to protect his/her fee.

____ ________________________

Attorney's Signature **Date**

Please sign, date and return one copy to our office – keep one copy for your records.

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No-Show and Cancellation Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when 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 schedule.

In the event an appointment is missed or cancelled with less than 24 hours' notice or no notice, a $25 charge will be billed and this is not covered by your insurance company.

If you have an extenuating circumstance that makes it impossible for you to either come to your appointment or to give us notice of your cancellation, please let the staff know of your situation and we will reconsider assessing the "no show" charge on a case by case basis.

Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctor on time.

If you are 15 minutes past your scheduled time we will have to reschedule your appointment.

___________________________	___________________________	___/___/___
Printed Name of Patient	**Signature of Patient/Guardian**	**Date**

Acknowledgment OF RECEIPT OF HIPAA PRIVACY NOTICE

I, ____, have received a copy of this office's Notice of Privacy Practices when requested. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

___________________________	___________________________	___/___/___
Printed Name of Patient	**Signature of Patient/Guardian**	**Date**