



**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

**Smoking Status (age 13 and over)**

Never  Former  
 Current Daily  Occasional  
 Heavy  Light

\_\_\_\_\_  
Your Last Name

\_\_\_\_\_  
Your Social Security Number

\_\_\_\_\_  
Your First Name

\_\_\_\_\_  
Your Middle Name (of Initial)

**Marital Status**  Married

Single  Divorced  
 Widowed  Separated

\_\_\_\_\_  
Address

\_\_\_\_\_  
Preferred Language

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Spouse's Name

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Child's Name and Age

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Cell Carrier

\_\_\_\_\_  
Child's Name and Age

\_\_\_\_\_  
Emergency Contact Name & Phone Number

\_\_\_\_\_  
Child's Name and Age

\_\_\_\_\_  
Your Occupation

\_\_\_\_\_  
Work Phone

\_\_\_\_\_  
Your Employer

**May we contact you at work?**

Yes  No

\_\_\_\_\_  
Primary Care Provider's Name and Phone Number

**Preferred method of Contact?**

Home Phone  Cell Phone  
 Work Phone  Email  
 Text Messages

\_\_\_\_\_  
Insured's First and Last Name

\_\_\_\_\_  
Insured's DOB

\_\_\_\_\_  
Insurance Carrier

\_\_\_\_\_  
Policy Number

\_\_\_\_\_  
Address & Phone Number

\_\_\_\_\_  
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: \_\_\_\_\_  
\_\_\_\_\_

**Secondary Complaint**

The secondary symptom that prompted me to seek care today is: \_\_\_\_\_  
\_\_\_\_\_

**Additional Complaint**

The additional symptom that prompted me to seek care today is: \_\_\_\_\_  
\_\_\_\_\_

**Location**

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

**And are the result of:**

An accident or injury  
 Work  Auto  Other \_\_\_\_\_

**And are the result of:**

An accident or injury  
 Work  Auto  Other \_\_\_\_\_

**And are the result of:**

An accident or injury  
 Work  Auto  Other \_\_\_\_\_

A worsening long-term problem  
 An interest in:  Wellness  
 Other \_\_\_\_\_

A worsening long-term problem  
 An interest in:  Wellness  
 Other \_\_\_\_\_

A worsening long-term problem  
 An interest in:  Wellness  
 Other \_\_\_\_\_

**Onset** (When did you first notice your current symptoms?) \_\_\_\_\_

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**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 \_\_\_\_\_

**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 \_\_\_\_\_

**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:**

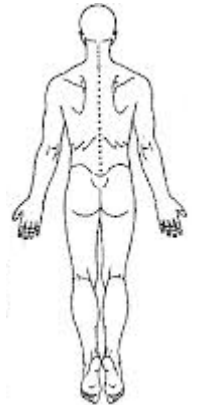
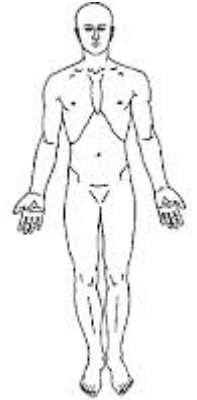
Standing  Lying down  
 Bending  Coughing  
 Twisting  Walking  
 Sitting  Lifting

**Check any activities which aggravate this:**

Standing  Lying down  
 Bending  Coughing  
 Twisting  Walking  
 Sitting  Lifting

**Check any activities which aggravate this:**

Standing  Lying down  
 Bending  Coughing  
 Twisting  Walking  
 Sitting  Lifting



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: \_\_\_\_\_

Check here if you have a family history of:

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: \_\_\_\_\_

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

- Arthritis
- Diabetes
- Cancer
- Cardiovascular Disease

\_\_\_\_\_  
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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02886

## FINANCIAL AGREEMENT

The doctor and staff of Enos Chiropractic Center welcome you as a patient and are pleased that you chose us to provide your medical care. We are committed to your treatment being successful. Please understand that payment of our bill is considered a part of your treatment. The following is a statement of our financial/office policy, which we require that you read and sign prior to any treatment. All patients must complete our information and insurance form before seeing the doctor.

We have advised you that we do not participate in all insurance programs and that certain services in some cases are not covered by insurance. We reserve the right to perform services and utilize certain professional staff to assist us in your care regardless of your insurance coverage. Our office policy is to receive payment at the time services are rendered. We encourage you to ask questions and make sure you fully understand what your responsibilities are, because you are ultimately responsible for paying for all services you receive. We are available to explain some of the general parts of how your insurance will cover the services provided by our practice, but only your insurance company will have the specifics of how your plan works.

A finance charge of 1.25% per month (15% annually) with a \$10 per month billing charge may be charged on all past due accounts along a \$25 fee will be charged on any returned check. In the event of nonpayment of an account, I understand that I will be responsible for all collection costs, including reasonable attorney fees, incurred for the collection of said balance.

## GENERAL CONSENT/AUTHORIZATIONS

I hereby give Enos Chiropractic Center consent for those services deemed medically necessary appropriate by the attending provider.

I request that payment of authorized Medicare or any other insurance benefits be made on my behalf to Enos Chiropractic Center for any services provided to me by that group. I understand that any holder of medical information about me may release any information to the Health Care Finance Administration (HCFA) and its agents in order to facilitate reimbursement for services rendered. I authorize Enos Chiropractic Center to release information to all parties and/or their representatives that may be required to provide or pay for services rendered.

I understand that the above consent/authorizations do not guarantee payment/reimbursement, nor does it release me from any obligation and responsibility for all outstanding charges not covered as a result of, but not exclusive to: copayments, co-insurance, deductibles, usual and customary schedules, maximum allowances/limits or non-covered services.

I understand that if may be necessary to use a photocopy or facsimile of this assignment and that it is to be considered as valid as the original.

## PATIENT'S RESPONSIBILITY FOR MEDICAL CARE

During the course of your evaluation and treatment, your doctor may suggest that you have certain tests done, be evaluated by a physician of a different specialty, or return to this office on a future date for re-evaluation. In consideration of this, and your health, we ask that you keep all scheduled appointments and associated commitments. If you have any questions concerning the recommended treatment, please be sure to have them addressed during your visit or by phone should questions come up after your visit. The continuity of you care often depends on your full cooperation and open communication. If, for some reason, you cannot proceed with your doctor's recommendations, please let us know as soon as possible. Your doctor relies on your honest and complete feedback and will respect your decision. In regards to results from your visits or completed tests, we will call you when we have the results, but please feel free to call this office to request the information. It is important that you understand the consequences of not following through with recommended testing or scheduled appointments. Your signature below acknowledges your understanding of the importance of proceeding with the treatment plan as recommended and the subsequent consequences of not doing so.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(PATIENT/PARENT/GUARDIAN)



### ***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**