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

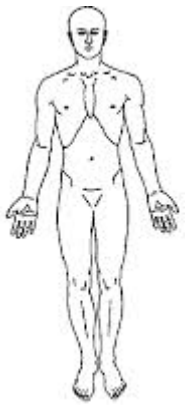
Date (MM/DD/YYYY)

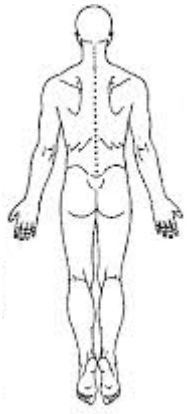
Patient Name _____ **Patient Number** (office use only) _____

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

Primary Complaint	**Secondary Complaint**	**Additional Complaint**
The primary symptom that prompted me to seek care today is: _____	The secondary symptom that prompted me to seek care today is: _____	The additional symptom that prompted me to seek care today is: _____
And are the result of:	**And are the result of:**	**And are the result of:**
◯ An accident or injury ◯ Work ◯ Auto ◯ Other_____	◯ An accident or injury ◯ Work ◯ Auto ◯ Other_____	◯ An accident or injury ◯ Work ◯ Auto ◯ Other_____
◯ A worsening long-term problem	◯ A worsening long-term problem	◯ A worsening long-term problem
◯ An interest in: ◯Wellness ◯ Other _____	◯ An interest in: ◯Wellness ◯ Other _____	◯ An interest in: ◯Wellness ◯ Other _____
Onset (When did you first notice your current symptoms?) _____	**Onset** (When did you first notice your current symptoms?) _____	**Onset** (When did you first notice your current symptoms?) _____
Prior interventions (What have you done to relieve the symptoms?)	**Prior interventions** (What have you done to relieve the symptoms?)	**Prior interventions** (What have you done to relieve the symptoms?)
◯ Prescription medication ◯Acupuncture	◯ Prescription medication ◯Acupuncture	◯ Prescription medication ◯Acupuncture
◯ Over the counter drugs ◯ Chiropractic	◯ Over the counter drugs ◯ Chiropractic	◯ Over the counter drugs ◯ Chiropractic
◯ Homeopathic remedies ◯ Massage	◯ Homeopathic remedies ◯ Massage	◯ Homeopathic remedies ◯ Massage
◯ Physical therapy ◯ Ice	◯ Physical therapy ◯ Ice	◯ Physical therapy ◯ Ice
◯ Surgery ◯ Heat	◯ Surgery ◯ Heat	◯ Surgery ◯ Heat
◯ Other _____	◯ Other _____	◯ Other _____
Check any activities which aggravate this:	**Check any activities which aggravate this:**	**Check any activities which aggravate this:**
◯ Standing ◯ Lying down	◯ Standing ◯ Lying down	◯ Standing ◯ Lying down
◯ Bending ◯ Coughing	◯ Bending ◯ Coughing	◯ Bending ◯ Coughing
◯ Twisting ◯ Walking	◯ Twisting ◯ Walking	◯ Twisting ◯ Walking
◯ Sitting ◯ Lifting	◯ Sitting ◯ Lifting	◯ 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: _____

Check here if you have a family history of:

◯ Arthritis
◯ Diabetes
◯ Cancer
◯ Cardiovascular Disease

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

_____ **Patient (or Guardian's) signature**

_____ **Date (MM/DD/YYYY)**

Enos Chiropractic Center *12 Calef Street, Warwick, RI 02886* *p: 401-921-6550 f: 401-921-6552*

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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WORKERMANS COMPENSATION QUESTIONAIRE

1. What was the date of the accident? _____
2. What time did the accident occur? _____
3. What is the name of your employer? _____
4. What is the street address of your employer? _____
5. What is the city, state and address of your employer? _____
6. What is the name of your attorney? _____
7. What is the street address of your attorney? _____
8. What is the city, state and zip of your attorney? _____
9. Please describe your incident in a few sentences _____

   _____

   _____

   _____

10. Did you report the incident to your supervisor? _____
11. What's your supervisor's name? _____
12. Did your employer send you to a doctor? If yes, please provide the doctor's name _____
13. Did you go to a doctor on your own? If yes, please provide the doctor's name _____
14. Where you prescribed anything at the hospital? (check all that apply)
    ◯ pain medication ◯ muscle relaxers ◯ neck brace ◯ other: _____
15. Did you receive any stitches for any cuts at the hospital? ◯ no ◯ yes, please describe _____
16. Were any X-Rays/CT scans/MRIs taken at the hospital? ◯ no ◯ yes, please describe _____
17. Are there any other problems that affect your employment? _____

    _____

18. Does your job cause you to favor one side of your body? _____
19. Before the injury, were you capable of performing equal work with others your age? _____
20. Have you injured this area before? ◯ yes ◯ no
21. 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)**

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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

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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**