EVANS SPORT & SPINE
Chiropractic Center

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New Patient Intake

PATIENT INFORMATION **DATE**: _____

First Name: _____Middle Initial: _____ Last Name: _____

Date of Birth: _____ Social Security Number: _____-_____-_____

Address: _____

City: _____ State: _____ Zip Code: _____

Home: _____ Cell: _____ Work: _____

Email Address_____ Preferred Method of Contact ☐ **Text** ☐ **Call** ☐ **Email**

Occupation: _____ Employer: _____

Emergency Contact: _____ Relationship: _____ Number: _____

How did you learn about our office? _____

MEDICAL HISTORY

Chief Complaint/ Purpose of Appointment: _____

This Complaint is due to: ☐ **Auto Accident** ☐ **Work** ☐ **Other** (describe) _____

Have you been seen by another Doctor for this problem? ☐ **Yes** ☐ **No**

Date that symptoms appeared: _____

Are you Pregnant or is there any chance of you being Pregnant? ☐ **Yes** ☐ **No**

Please list all past surgeries: _____

_____

Please list medications that you are currently taking: _____

_____

Please list any previous incidents of an accident: _____

PERSONAL INJURY PATIENTS ONLY

Date of Accident: _____Did you go to the Emergency Room? ☐ **Yes** ☐ **No**

Do you have an Attorney? ☐ **Yes** ☐ **No** Attorney's Name/Law Firm_____

Attorneys' Number: _____

*If **NO**, how are you paying for treatment*? ☐ **Auto Insurance** ☐ **Med-Pay** ☐ **Out of Pocket**

If via Auto Insurance, please let Front-Desk know so we can get the policy information

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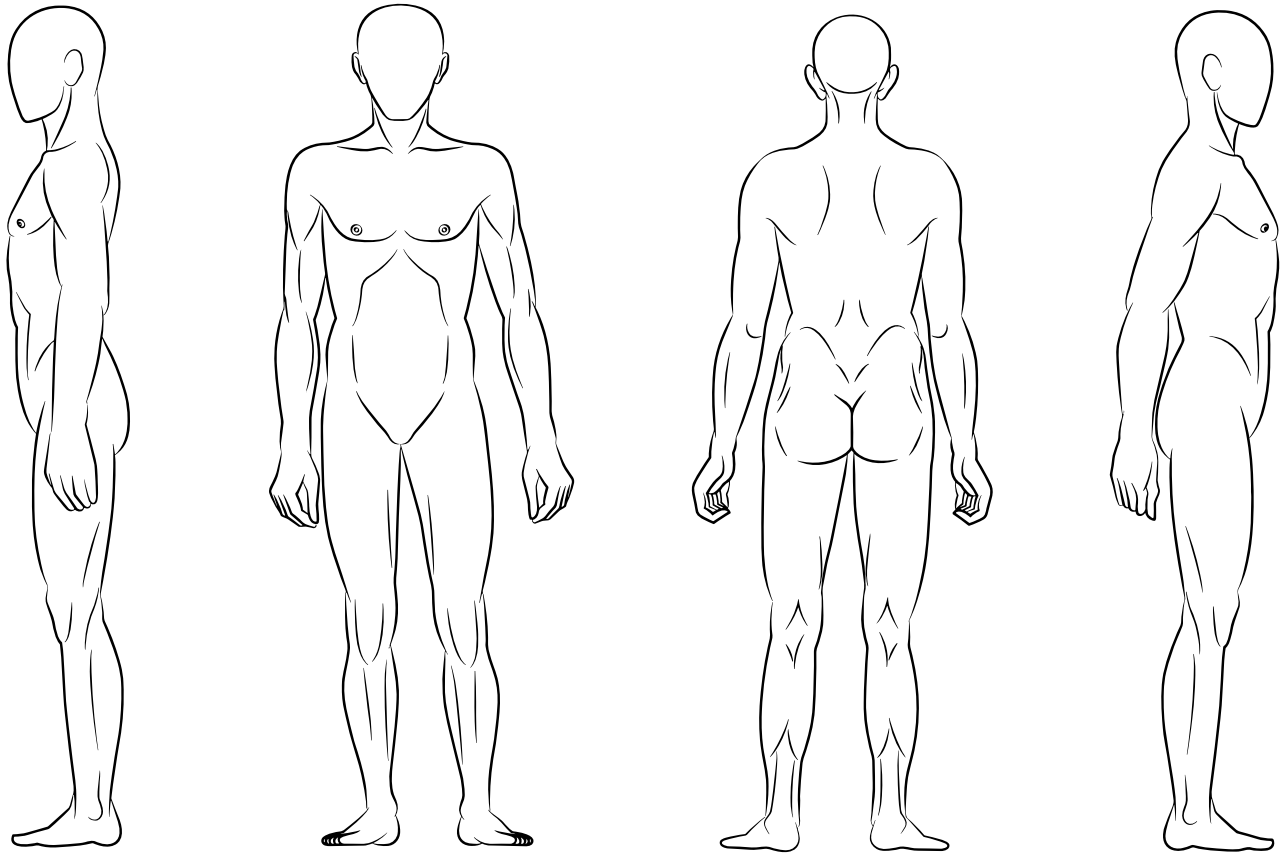
PAIN LOCATION

Please mark the areas where you are experiencing pain using the following diagram and letters:

P- PAIN **N-** NUMBNESS **T-** TINGLING **B**- BURNING



On a scale 1 to 10 with 10 being the most severe, select a number that best represents your level of pain.

1 2 3 4 5 6 7 8 9 10

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INFORMED CONSENT

The Material Risk Inherent in Chiropractic Adjustments

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to; fractures, disc injuries, dislocation, muscle strain, cervical myelopathy, costovertebral strains, separation, and burns. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contradictions to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform the chiropractor.

The Probability to Those Risk Occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bones which the chiropractor will check during the taking of the history and during examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The Availability and Nature of Other Treatment Options

Other treatment options for you condition may include:

- Self –administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- Hospitalization
- Surgery

If you choose to use one of the above noted “other treatment” options, you should be aware that there are risk and benefits of such options and you may wish to discuss these with your primary medical physician.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPORPRIATE BOX AND SIGN BELOW

I have read ☐ or have had read to me ☐ the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the chiropractor and have had my questions answered to me satisfaction. By signing below I state that I have weighed the risk involved in undergoing treatment and have decided that it is in my best interest to undergo treatment recommended. Having been informed of the risk, I hereby give my consent to that treatment.

Patient/Guardian Signature_____

Date:_____

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AUTHORIZATION AND RELEASE

I acknowledge and agree that I am financially responsible for all services rendered to me by Evans Sport and Spine, regardless of insurance coverage or third-party involvement.

In the event that I fail to make timely payment on any outstanding balance, I understand that my account may be referred to a collection agency or attorney for further action.

Should this occur, I agree to be responsible for any and all additional costs incurred in the collection of my account. These costs may include, but are not limited to, collection agency fees, reasonable attorney's fees, and court costs, as permitted by applicable laws governing such transactions.

I further understand that these additional charges are my legal obligation and will be added to the balance owed until the account is paid in full.

PATIENT/GAURDIAN SIGNATURE: _____

DATE:_____

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X-RAY POLICY AND CONSENT

At Evans Sport and Spine, our priority is your safety, well-being, and the accuracy of your diagnosis. In some cases, chiropractic physicians may determine that x-rays are medically necessary in order to properly evaluate your condition and to safely proceed with treatment.

Financial Responsibility

I understand and agree that if the chiropractor deems x-rays necessary, it is my responsibility as the patient to pay for any and all x-rays performed.

- The cost for x-rays in this office is $50.00 per region (2 views).
- This fee includes taking the x-rays, the professional reading and interpretation of the images, and the preparation of a written clinical report that will become part of my permanent medical record.

Patient-Centered Standards of Care

I acknowledge that due to increasing oversight and limitations placed on the healthcare profession, our chiropractic physicians remain committed to delivering care that is both safe and effective. Treatment recommendations—including the use of x-rays—are made with the same standard of compassion and responsibility as if the patient were a member of the provider's own family.

Consent and Authorization

By signing below, I authorize Evans Sport and Spine and its chiropractic physicians to perform diagnostic x-rays if deemed clinically necessary for my condition. I also agree to the financial terms listed above and acknowledge my responsibility for payment.

I have had the opportunity to ask questions regarding this consent, and all of my questions have been answered to my satisfaction.

PATIENT/GAURDIAN SIGNATURE: _____

DATE:_____

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FINANCIAL POLICIES AND AGREEMENT

At Evans Sport & Spine, we are committed to providing quality care in a professional and efficient manner. To ensure transparency and mutual understanding, the following financial policies apply to all patients:

1. Cash-Based Practice

- Evans Sport & Spine operates as a cash-based office.
- We do not bill insurance on your behalf, as many of the therapies and services provided in our office are not covered by insurance carriers.
- All services must be paid for directly by the patient at the time of service. Patients are welcome to use Health Savings Accounts (HSA) or Flexible Spending Accounts (FSA), if applicable.

2. Missed Appointments & Cancellations

- All cancellations require 24-hour advance notice.
- Same-day cancellations and no-shows will result in a $60.00 missed appointment charge added to your account.
- All missed appointment fees must be paid prior to rescheduling any future visits.
- Patients with repeated same-day cancellations or no-shows may have their ability to schedule appointments temporarily suspended at the discretion of Evans Sport & Spine.

3. Credit Card on File Policy

- I authorize Evans Sport & Spine to securely store my credit card information on file.
- I authorize Evans Sport & Spine to process payments using the card on file for the following:
  - Any unpaid balances on my account
  - Missed appointment fees as described above
- I understand that if my card is declined or payment is not received, my account may be subject to collection procedures, which could include collection agency fees, attorney fees, and court costs as permitted by law.

Acknowledgment & Agreement

I acknowledge that Evans Sport & Spine is a cash-based practice and does not bill insurance. I understand that I am fully responsible for all charges incurred. I have read, understood, and agree to the financial policies outlined above. I authorize Evans Sport & Spine to maintain my credit card on file and to process payments as described.

PATIENT/GAURDIAN SIGNATURE: _____

DATE:_____

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PHI Authorization

Patient Name: _____ DOB: _____
Phone: _____

I authorize Evans Sport and Spine to share the following with the person(s) listed below:

□ All Medical Records □ Appointment Info □ Billing Info □ Other: _____

Authorized Individual(s):

1. Name: _____ Relationship: _____ Phone: _____
2. Name: _____ Relationship: _____ Phone: _____

Method of Disclosure: □ Verbal □ Written □ Electronic

Expires: □ Specific Date: _____ □ End of Treatment □ Upon Written Revocation

I understand I may revoke this authorization in writing at any time, and that information disclosed may be re-disclosed and may no longer be protected by HIPAA.

Patient Signature: _____ Date: _____
Staff/Witness: _____ Date: _____