Lexington Family CHIROPRACTIC
You don't have to live with the pain!

CLIENT INTAKE

Today's Date ____/____/____

GENERAL INFORMATION

Patient Name_____ Preferred First Name_____

Address_____ Apt#_____

City_____ State_____ Zip_____

Home Phone:( )_____ Mobile ( )_____ Work ( )_____

Date of Birth____/____/_____ Age_____ Sex_____ SSN_____

Email Address_____ Height_____ Weight_____ Marital Status_____

Spouse Name_____ Children_____

Occupation_____ Employer_____

Emergency Contact_____ Emergency Contact Phone_____

Primary Care Physician_____ Address_____

PRIMARY INSURANCE INFO

Insurance Co. Name_____ ID#:_____ Group #:_____

Insured's Name_____ Relation to You _____ Insured's DOB _____

SECONDARY INSURANCE INFO

Insurance Co. Name_____ ID#:_____ Group #_____

Insured's Name_____ Relation to You _____ Insured's DOB _____

Have you ever had chiropractic care?_____ When?_____

Doctor's Name_____ Were you satisfied?_____

If no, please list reasons for dissatisfaction_____

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How did you hear about our office? Circle One

Friend Relative Yellow Pages Internet Insurance Provider List Mail

Which one of our clients should we thank for referring you?_____

HEALTH HISTORY

For the conditions below, please indicate if you have had the condition in the past or if you presently have the condition:

Past	Present	Condition	Past	Present	Condition
☐	☐	Allergies (seasonal)	☐	☐	High Blood Pressure
☐	☐	Anxiety	☐	☐	Hip Pain
☐	☐	Arthritis	☐	☐	HIV/AIDS
☐	☐	Asthma	☐	☐	Jaw Pain/TMJ
☐	☐	Blurred/Double Vision	☐	☐	Loss of Balance
☐	☐	Cancer	☐	☐	Low Back Pain
☐	☐	Depression	☐	☐	Low Blood Pressure
☐	☐	Diabetes	☐	☐	Low Blood Sugar
☐	☐	Digestive Problems	☐	☐	Lung Problems
☐	☐	Dizziness	☐	☐	Menstrual Problems
☐	☐	Drug/Alcohol Use	☐	☐	Mid Back Pain
☐	☐	Epilepsy/Seizures	☐	☐	Migraines
☐	☐	Erectile Dysfunction	☐	☐	Neck Pain
☐	☐	Fainting	☐	☐	Numb/Tingling Arms/Hands
☐	☐	Fibromyalgia	☐	☐	Numb/Tingling Legs/ Feet
☐	☐	Foot or Knee Problems	☐	☐	Osteoporosis
☐	☐	Headaches	☐	☐	Ringing in Ears
☐	☐	Heartburn	☐	☐	Scoliosis
☐	☐	Hearing Loss	☐	☐	Shoulder Pain
☐	☐	Heart Attack	☐	☐	Skin Problems
☐	☐	Heart Problems	☐	☐	Stroke
☐	☐	Hepatitis	☐	☐	Thyroid problems
			☐	☐	Upper Back Pain

Additional comments/problems/issues you would like the doctor to know:_____

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Please mark if you've ever had the following:

_____ Back Surgery If so, what kind?_____

_____ Pacemaker

_____ Defibrillator

_____ Car Accident If so, when? _____

_____ Slip/Falls If so, what?_____

_____ Broken Bones If so, where?_____

List any past surgeries:_____

_____

List all medications (If you don't know the names, please list what they are for):_____

_____

List any medication allergies:_____

For Females: Last Menstrual Period:_____Are you or could you be pregnant?_____

If yes, how many weeks?_____

Assignment & Release- *By signing below, I authorize Lexington Family Chiropractic to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Lexington Family Chiropractic and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

By signing below, I give my consent for examination and the performance of any tests or procedures needed. If the patient is a minor, by signing I give consent for examination, tests, and procedures for the above minor patient.

_____ _____

PATIENT'S NAME (PRINTED) TODAY'S DATE

_____

PATIENT'S SIGNATURE (or RESPONSIBLE PARTY)

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CURRENT COMPLAINT HISTORY SYMPTOM #1

Primary Symptom 1 (Circle): Neck Pain Mid Back Pain Low Back Pain Other:_____

How long have you had this symptom? _____

How did this symptom begin? □After a specific incident (describe)_____

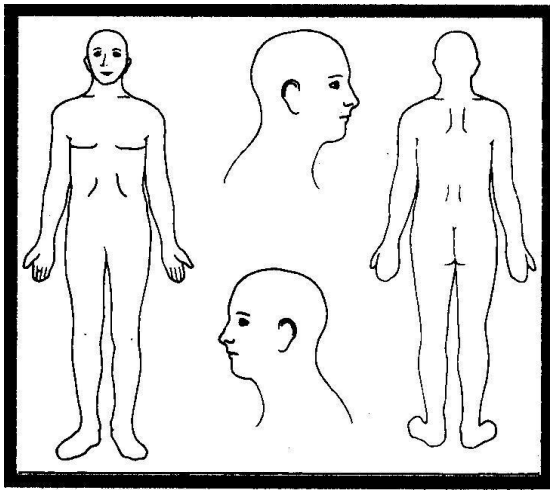
□After a car accident (date)_____ □Gradually developed over time □ Work Injury □Other_____

Description of pain or symptoms: □Sharp □Shooting □Dull □Burning □Ache □Numbness □Weakness □Tingling

□Throbbing □Stiffness □ Stabbing □Other_____

SHOW US YOUR PAIN—USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SYMPTOMS TODAY

H= SHARP G= SHOOTING B= BURNING A= ACHE N= NUMBNESS
W= WEAKNESS P= PINS & NEEDLES T= THROBBING
F= STIFFNESS S= STABBING O= OTHER



On a scale of 0-10, with 10 being the worst, circle the number that best describes the symptom most of the time:
0 1 2 3 4 5 6 7 8 9 10

Does your pain move or radiate? □Yes □No Where?_____

What makes your symptoms better? □Nothing □Lying Down □Standing □Sitting □Movement/Exercise □Rest □Ice □Heat

□Medication □ Massage □ Muscle Relaxers □Stretching □Other_____

What makes your symptoms worse? □Nothing □Lying Down □Standing □Sitting □Movement/Exercise □Rest

□Other_____

Frequency of pain or symptoms: □Constant (76-100%) □Frequent (51-75%) □Occasional (26-50%)

What activities are affected because of this symptom? □ADL's (activities to take care of yourself) □Employment □Sleeping

□Hobbies □Other_____

Has anyone treated you for this episode? □Yes □No If Yes, what type of treatment have you had?_____

Patient's Signature (Or Guardian):_____ **Date:**_____

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CURRENT COMPLAINT HISTORY SYMPTOM #2 AND #3

****If you do not have a second complaint, please write N/A and sign and date at bottom**

Symptom 2 (Circle): Neck Pain Mid Back Pain Low Back Pain Other:_____

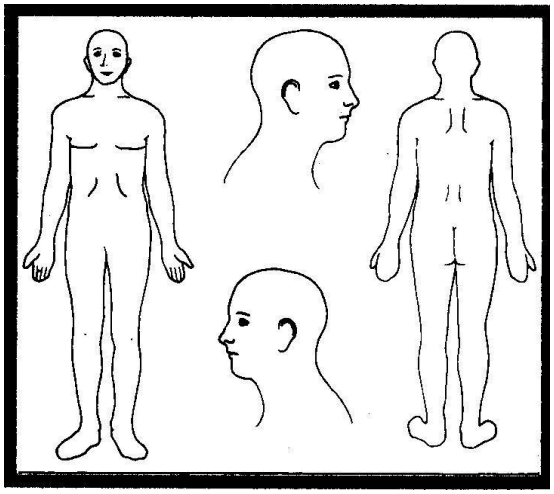
How long have you had this symptom? _____

How did this symptom begin? □ After a specific incident (describe)_____
□ After a car accident (date)_____ □ Gradually developed over time □ Work Injury □ Other_____

Description of pain or symptoms: □ Sharp □ Shooting □ Dull □ Burning □ Ache □ Numbness □ Weakness □ Tingling
□ Throbbing □ Stiffness □ Stabbing □ Other_____

SHOW US YOUR PAIN—USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SYMPTOMS TODAY

H= SHARP G= SHOOTING B= BURNING A= ACHE N= NUMBNESS
W= WEAKNESS P= PINS & NEEDLES T= THROBBING
F= STIFFNESS S= STABBING O= OTHER



On a scale of 0-10, with 10 being the worst, circle the number that best describes the symptom most of the time:
0 1 2 3 4 5 6 7 8 9 10

Does your pain move or radiate? □ Yes □ No Where?_____

What makes your symptoms better? □ Nothing □ Lying Down □ Standing □ Sitting □ Movement/Exercise □ Rest □ Ice □ Heat
□ Medication □ Massage □ Muscle Relaxers □ Stretching □ Other_____

What makes your symptoms worse? □ Nothing □ Lying Down □ Standing □ Sitting □ Movement/Exercise □ Rest
□ Other_____

Frequency of pain or symptoms: □ Constant (76-100%) □ Frequent (51-75%) □ Occasional (26-50%)

What activities are affected because of this symptom? □ ADL's (activities to take care of yourself) □ Employment □ Sleeping
□ Hobbies □ Other_____

Has anyone treated you for this episode? □ Yes □ No If Yes, what type of treatment have you had?_____

Symptom 3_____

Patient's Signature (Or Guardian):_____ **Date:**_____

Dr. Heath Gallentine & Assoc
131 Prosperous Place Suite 15
Lexington, KY 40509

Phone (859) 264-1140
Fax (859) 245-1190
www.lexfamilychiro.com

HIPAA Notice of Privacy Practices Acknowledgement
Initial Uses Authorization Form
Lexington Family Chiropractic PLLC

Effective: 01-02-2005

By signing this form, you acknowledge that you were presented with a copy of the Notice of Privacy Practices of Lexington Family Chiropractic PLLC. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information (PHI). We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices will be placed on display in the office at all times. You may obtain additional copies of our most current notice by requesting it from our privacy official, Kristy Gallentine.

If you have any questions regarding this notice or our health information privacy policies, please contact: Kristy Gallentine

You can reach the Privacy Official at: Lexington Family Chiropractic PLLC, 131 Prosperous Place Suite 15, Lexington, KY 40509, 859-264-1140. Hours Available: A message may be left for our privacy official any time the clinic is open and your call will be returned within 7 business days.

List any names for individuals you authorize us to speak to regarding your PHI and check the specific PHI authorized:

1. _____ ☐ All PHI ☐ Appt Info Only ☐ Specific:_____
2. _____ ☐ All PHI ☐ Appt Info Only ☐ Specific:_____
3. _____ ☐ All PHI ☐ Appt Info Only ☐ Specific:_____

Patient Name (Print): _____

Patient/Personal Representative (Signature): _____

Relationship of Personal Representative to Patient: _____

Date of Signature: _____

==========**Staff Use Only**==========

Staff complete only if NO signature is obtained, If it is not possible to obtain the patients acknowledgement, describe the good faith efforts made to obtain the individuals acknowledgement, and the reasons why the acknowledgement was not obtained.

Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices
Other:_____
Staff Signature: _____date: _____

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FINANCIAL POLICY

Lexington Family Chiropractic strives to provide the best quality of services to our patients. This letter is to acquaint you with our office billing procedures.

An Overview of Our Billing Procedure

PATIENTS WITH INSURANCE

We participate with most major insurance plans. Each plan's chiropractic benefits are different, therefore it is your responsibility to know what is covered under your plan, your eligibility, and your benefits. Based on your chiropractic benefits through your insurance, it will determine your out-of-pocket expense.

***Please note:** We may get information from your insurance company regarding your chiropractic coverage, however, we are not responsible for any misinformation or incomplete information we receive from them. It is ultimately your responsibility to know your benefits. Benefits quoted to us are not a guarantee of payment. Also, your benefits can change throughout the year depending on your plan coverage—therefore, the amount you owe could change throughout the year. We do our best to provide you with the best information that we know at the time of service, however, any changes from that processed by your insurance company is not our fault or responsibility. **The coverage from your insurance company depends upon the plan purchased by his/her employee, not the fees of the doctor.**

Each procedure done in our office, which includes an exam, x-rays, chiropractic adjustment, and therapies must be billed to the insurance company separately for reimbursement.

SECONDARY INSURANCE

It is your responsibility to provide us with any secondary insurance that you have. We will submit to your secondary once we receive your processed visits from your primary. Please note that most secondary insurances only cover coinsurances and may not cover copays and/or deductibles. The amount owed after processing through your secondary still remains your responsibility.

PATIENTS WITHOUT INSURANCE

Our office provides a "Time of Service Fee" for those without insurance. This fee is due in full at the time of the visit.

MEDICARE

We do accept assignment from Medicare. Medicare will only cover manipulation of the spine. Medicare pays 80% of the allowable fee once your deductible has been met. You are required to pay the deductible and the remaining 20%. Any non-covered services and fees will be discussed with you before those treatments occur. You will be required to sign an Advanced Beneficiary Notice (ABN) regarding any non-covered services.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

We will submit your care to your auto insurance, however, we need your auto insurance company's name, address, claim adjuster's name and contact info. We also need your claim number to process the visits. Notify our office immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we may wait for settlement of your claim after your care is initiated. Once the claim is settled or if you suspend or terminate care, any fees for services are due by you immediately.

"ON THE JOB" INJURY (WORKER'S COMPENSATION)

If you are injured on the job, you will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within three months, or if you suspend or terminate care, any fees and services are due by you immediately.

Initial _____

FINANCIAL POLICY (CONT)

Your Responsibility As The Patient

As a patient at our office, you have a responsibility to do the following:

1) Patients **must provide us with a copy of your insurance card** for accurate billing. If your insurance changes, it is your responsibility to give us your updated card.
2) Patients are responsible for paying their copay, coinsurances, and deductibles at the time of service. Any quotes given to you from our staff are an estimate. Our office can **NEVER** guarantee insurance coverage for any service provided by our office. If you are unsure of your coverage benefits, call the customer service number on your insurance card or talk with someone in your HR department. **It is the patient's responsibility to be aware of how their insurance plans work and your benefit package. Every patient's insurance policy is different and it is beyond the ability of our staff to know the benefits of every plan.**
3) Patient's are responsible for paying all charges not covered by their health insurance plans.
4) The office will submit a claim up to two times per appointment; further insurance appeal will become the patient's responsibility.
5) **Since the agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care.** Your insurance company will let you and our office know if further information is needed from us (i.e: x-rays, written documentation, etc.)
6) **Patient's are responsible for balances in full 30 days after your first statement is sent.** The practice cannot carry balances longer than 90 days. **Balances over 90 days will be sent to collections**. In the event that a patient's account is turned over to collections, 10% of that total will be added to the account. The patient is also responsible for all collection fees charged by the collection agency. It is understood and agreed that x-rays will not be released if there is a balance on a patient's account.
7) Patient's are responsible for all returned personal checks. **A service charge of $30 will be assessed for all returned checks.**
8) Patients are responsible to call or text for any appointments that need to be canceled or changed.. **A $25 fee will be charged for all appointments that are no-showed.**

Assignment Of Benefits

I authorize that any insurance benefits or reimbursement for services rendered which amounts would otherwise be payable to me under any insurance, pre-paid healthcare plan, or Medicare, be made directly to:

Lexington Family Chiropractic, PLLC
Dr. Heath Gallentine
131 Prosperous Place Suite 15
Lexington, KY 40509

I have read, accept, and understand the above Financial Policy of Lexington Family Chiropractic and agree to all payment terms. My signature gives this office permission to give out any pertinent information to any insurance company, attorney, or adjustor who needs this information to facilitate the payment of a claim. I also authorize the charge of a $25 fee for any appointments that are no-showed. A photocopy of this form shall be deemed valid.

Patient Name (Print): _____

Patient/Personal Representative (Signature): _____

Relationship of Personal Representative to Patient: _____

Date of Signature: _____

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INFORMED CONSENT TO TREAT

I, _____, hereby request and consent to the performance of conservative, noninvasive chiropractic procedures, including spinal manipulation/adjustment and various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by Dr. Gallentine and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for Dr. Gallentine, including those working at Lexington Family Chiropractic, whether signatories to this form or not.

Nature of Chiropractic Treatment

Prior to beginning treatment, you will be given a physical examination that can include range of motion testing, muscle strength testing, palpation, orthopedic testing, neurological testing, and x-rays. Once your condition has been diagnosed, the primary method of treatment will be spinal manipulation, also known as spinal adjustment. An adjustment is a quick, precise movement of the spine over a short distance. Adjustments are usually performed by hand but may be performed by a hand-guided mechanical instrument, such as an Activator. During a spinal adjustment, you may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. This sound is created by gas escaping the joints upon movement and is completely safe. Various physical therapy procedures, such as hot or cold packs, electric muscle stimulation, traction, stretching, and exercises may also be used.

Treatment Results And Risks

I understand and I am informed that, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all healthcare treatments, in the practice of chiropractic, there are some risks to treatment, including, but not limited to, soreness, muscle spasm for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains, and physical therapy burns.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

Alternative Treatments Available

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to: self-administered, over-the-counter analgesics; medical care with prescription drugs such as anti-inflammatories, muscle relaxants, and painkillers; rest; steroid injections; bracing; surgery; no treatment. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Patient Name (Print): _____

Patient/Personal Representative (Signature): _____

Relationship of Personal Representative to Patient: _____

Date of Signature: _____