TURNING POINT
CHIROPRACTIC

NEW PATIENT INTAKE FORM

Thank you for choosing us to take care of your health care needs! In order for us to get to know you better, please take the time to fill out the following information. If you have any questions, please ask for assistance.

PATIENT REGISTRATION

First Name:_____ M.I.:_____ Last Name:_____

Nickname/Preferred Name:_____

Physical Address:_____

City/State/Zip:_____

Mailing Address:_____

City/State/Zip:_____

Home phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Email:_____

SSN:_____ Birth Date:_____ Age:_____ Sex: ❑ M ❑F

Occupation:_____ Employer:_____

Employer's Address:_____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed Other:_____

Spouse's Name:_____ # of Children:_____

Have you seen a chiropractor before? ❑ Yes ❑ No Name:_____ Date:_____

Do you have a family Physician? ❑ Yes ❑ No

Name:_____ Phone:_____

Address:_____

City/State/Zip:_____

How did you hear about our office? ❑ Google_____

❑ Yelp_____

❑ Facebook_____

❑ Friend/Family_____

❑ Other _____

EMERGENCY CONTACT

Name:_____ Relation:_____

Home Phone: (_____)_____ Other: (_____)_____

Address:_____

PLEASE GO TO NEXT PAGE

HEALTH HISTORY

What is your major complaint?_____

Date Symptoms Started: _____/_____/_____ **Did this happen at work?** ❑ Yes ❑ No

How did they start?_____

How bad are your symptoms?

None 0 1 2 3 4 5 6 7 8 9 10 *Severe*

How often do you experience symptoms?

_____ %

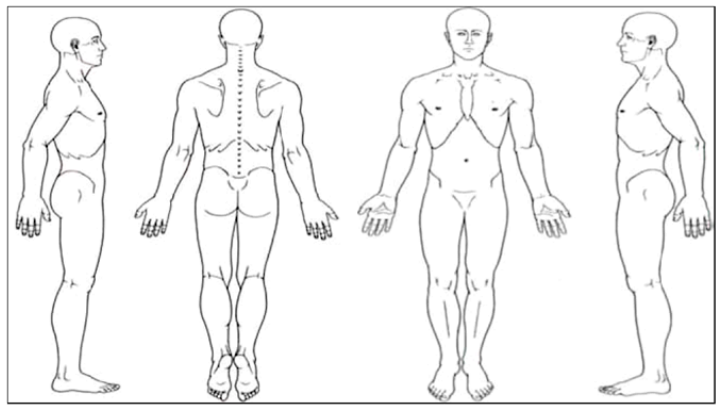
What do your symptoms feel like?

- ☐ Sharp
- ☐ Burning
- ☐ Dull ache
- ☐ Shooting
- ☐ Numb
- ☐ Tingling

How are your symptoms changing?

☐ Better ☐ No Change ☐ Worse

Indicate where you have pain or symptoms



What makes it better?_____

What makes it worse?_____

Have you seen another doctor for this? ❑ Yes ❑ No

Doctor's Name:_____ **Date Consulted:**___/___/_____ **Diagnosis:**_____

Did you have ❑ x-rays *Date:*_____ ❑ MRI *Date:*_____ ❑ CT Scan *Date:*_____

Do you have any devices to help with the symptoms (ie. lift, brace, walker...etc)? ❑ Yes ❑ No

If so, explain:_____

What type of regular exercise do you perform? ☐ None ☐ Light ☐ Moderate ☐ Strenuous

What is your height and weight? Height | | | | Weight | | | | lbs.

Feet *Inches*

Are you pregnant? ☐ Yes ☐ No Due Date:___/___/_____

Were you ever on birth control? ☐ Yes ☐ No When:_____ Type:_____

Did you ever smoke? ☐ Yes ☐ No How Long?_____ When did you quit?_____

Do you drink alcohol? ☐ Yes ☐ No **How many drink per week?**_____

List all prescription and over-the-counter medications, and supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ **Date:**_____

_____ **Date:**_____

_____ **Date:**_____

_____ **Date:**_____

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present	
❑	❑	Headaches
❑	❑	Neck Pain
❑	❑	Upper Back Pain
❑	❑	Middle Back Pain
❑	❑	Lower Back Pain
❑	❑	Shoulder Pain
❑	❑	Elbow Pain/Upper Arm Pain
❑	❑	Wrist Pain
❑	❑	Hand Pain
❑	❑	Hip/Upper Leg Pain
❑	❑	Knee/Lower Leg Pain
❑	❑	Ankle/Foot Pain
❑	❑	Jaw Pain
❑	❑	Joint Stiffness/Swelling
❑	❑	Arthritis
❑	❑	Rheumatoid Arthritis
❑	❑	General Fatigue
❑	❑	Muscular Incoordination
❑	❑	Visual Disturbances
❑	❑	Dizziness

Past	Present	
❑	❑	High Blood Pressure
❑	❑	Heart Attack
❑	❑	Chest Pain
❑	❑	Stroke
❑	❑	Angina
❑	❑	Kidney Stones
❑	❑	Kidney Disorders
❑	❑	Bladder Infection
❑	❑	Painful Urination
❑	❑	Loss of Bladder/Bowl Control
❑	❑	Prostate Problems
❑	❑	Abnormal Weight Loss/Gain
❑	❑	Loss of Appetite
❑	❑	Abdominal Pain
❑	❑	Ulcer
❑	❑	Hepatitis
❑	❑	Liver/Gall Bladder Disorder
❑	❑	Cancer
❑	❑	Tumor
❑	❑	Asthma
❑	❑	Chronic Sinusitis

Past	Present	
❑	❑	Diabetes
❑	❑	Excessive Thirst
❑	❑	Frequent Urination
❑	❑	Smoke/Use Tobacco Products
❑	❑	Drug/Alcohol Dependence
❑	❑	Allergies
❑	❑	Depression
❑	❑	Systemic Lupus
❑	❑	Epilepsy
❑	❑	Dermatitis/Eczema/Rash
❑	❑	HIV/AIDS

Other Health Problems/Issues

❑ ❑ _____

❑ ❑ _____

❑ ❑ _____

Is there any additional information you would like the doctor to know?_____

_____

AUTHENTICATION

I, the undersigned, hereby acknowledge that all of the information I provided is true and accurate to the best of my knowledge and that the doctors at Turning Point Chiropractic, PLLC will use this document as a tool to formulate a treatment plan for the health status described above.

Patient Signature:_____ Date:_____

Witness/Guardian Signature (If under 18):_____

DOCTOR'S NOTES

GI/GU:_____

Social:_____

BP/Pulse:_____

_____

_____

_____

Dr. Adam N. Favro, Chiropractor _____ **Date:**_____

TURNING POINT
CHIROPRACTIC

125 High Rock Ave. Suite 100
Saratoga Springs, NY 12866
ph: 518-584-9500
fax: 518-584-9501

www.TPCwellness.com

FINANCIAL POLICY

Patient Name: _____
Date: _____

Thank you for choosing Turning Point Chiropractic. Our goal is to provide you with the highest quality chiropractic care to fit your individual healthcare needs. Due to some frequent questions we receive regarding patient and insurance responsibility for services rendered we have been advised to develop this financial policy. Please read it, ask any questions you have have and sign in the space below. A copy will be provided to you upon request.

INSURANCE We participate with most major insurance plans. If you are **not** insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with, but do not have an up-to-date insurance card, payment in full is required until we verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you have regarding your coverage. If we participate with your plan, we are required to bill your plan for the services performed.

PROOF OF INSURANCE All patients must fill out the required paperwork before seeing the doctor. We must obtain a copy of your most recent insurance card as well as a photo ID to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

CO-PAYMENTS AND DEDUCTIBLES All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. We will do our best to give you an estimate of the cost of each visit, but your insurance company and plan details may vary. In the case we have overcharged, you will receive the difference in the form of a check. If there is a balance, it must be paid before your next visit.

NON COVERED SERVICES Some insurance carriers only reimburse for certain services. In the case that a service is not covered, you are responsible for the payment of that services. We will do our best to let you know if there is a service performed that your insurance will not cover. Again, we ask that you understand your benefits.

CLAIM SUBMISSION As a courtesy to you, we will submit your claims and assist you in any way we responsibly can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract. Claims can take anywhere from two weeks to eight weeks to be processed.

MISSED APPOINTMENTS Our policy is to charge $25.00 per missed appointment. We ask that you cancel your appointment 24 hours in advance. Appointments not cancelled 24 hours in advance will be subject to the missed appointment fee. This appointment fee of $25 is your responsibility and billed directly to you.

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Patient Acknowledgement:

I understand that the above information is not a guarantee of insurance benefits. Benefits will be determined by a number of factors by my insurance company, including but not limited to, eligibility at the time the services are rendered or medical necessity. The information contained in this document with respect to prices is an estimate. I assume responsibility for all charges incurred on my account. I understand and agree that no doctor can or should guarantee results for any course of treatment and that no spinal correction can be guaranteed. I understand that I am responsible for all payments after any deductible, co-payment and co-insurance is applied. I understand that my insurance is an agreement between me and my insurance company and all services rendered to me are my responsibility.

I understand that I have the option to decline and/or discontinue care at this office for any reason. In the event that care is discontinued, I will not be penalized in any fashion. Any unpaid balance associated with care which has been rendered shall continue to be payable. If there is credit remaining on my account, it will be refunded in the form of a check.

I have read, understand and agree to the above financial policy. I acknowledge that I am signing this notice voluntarily and that it is not being signed after services have been provided. I have had ample opportunity to ask questions about my financial obligation and other treatment options. I understand that by signing this form I am fully responsible for all non-covered services and any out of pocket costs associated with the covered services I receive.

_____ _____

Patient Printed Name Date

_____

Patient Signature

NEXT PAGE

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PRIVACY POLICY

The Practice:

(a) is required, by federal law, to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(b) under the Privacy Rule, may be required by state law to grant greater access or maintain greater restrictions on the use or release of your PHI that that which provided under federal law.

(c) is required to abide by the terms of the Privacy Notice

(d) reserves the right to change the terms of this Privacy Notice and to make the new privacy Notice provisions effective for all of your PHI that is maintain.

(e) will distribute any revised Privacy Notice to you prior to implementation.

(f) will not retaliate against you for filing complaint

Patient Communications:

Health Insurance Privacy act of 1996 requires we inform you of the following government stipulations in the order for us to contact you with educational and promotional items in the future vial email, US mail, telephone, and/or prerecorded messages. We **WILL NOT** ever share, sell, or "SPAM" your personal contact information.

Marketing is any communication about a product or service that encourages recipients to purchase or use the product or service. Communication can be defined as Voice Blasts, Email, and numerous marketing pieces. Communications to describe health-related products or services, or payment for them, provided by or included in a benefit plan of the covered entity making communication:

(a) Communications about participating providers in a provider or health plan network, replacement of or enhancements to a health plan, and health related products of services available only to health plan's enrollees that add value to, but are not part of, the benefit plan.

(b) Communication for treatment of the individual.

(c) Communications of case management or care coordination for the individual, or to direct or recommend alternative treatments, therapies, health care providers or care settings to individuals.

*I acknowledge receipt of this notice, and my understanding and my agreement to its terms.

Patient Name:_____

Patient Signature:_____ Date:_____