Long's Chiropractic Health Services

NEW PATIENT INTAKE FORM

3141 Columbia Ave
Lancaster, PA 17603
Phone: (717) 394-6558

PATIENT INFORMATION

Full Name:	**Date of Birth:**	**Age:**	**Today's Date:**
Address:	**Social Security Number:**		
City:	**State:**	**Zip Code:**	
Gender: ❑ Male ❑Female ❑ Other: **PREFERRED PRONOUN:** ❑She/Her ❑He/Him ❑They/Them	**Marital Status:** ❑Single ❑Married ❑Partnership ❑Separated ❑Divorced ❑Widowed		
Cell Phone Number:	**Home Phone Number:**	**E-mail:**	
May we add you to our office email list? ❑YES❑NO	**May we contact you by text/e-mail about missed appointments?** ❑TEXT ❑E-MAIL		
Occupation:	**Employer:**		
Work Address:	**Work Phone Number:**		
Ethnicity:	**Race:**	**Preferred Language:**	
Reason for choosing this clinic/who referred you:			
Height: _____ Weight: _____	**(OFFICE USE) BP R/L Arm: _____**		
Are you currently pregnant or nursing? ❑ Yes, ____ weeks pregnant ❑Nursing ❑No ❑ Not sure if I'm pregnant			

IN CASE OF EMERGENCY

Emergency Contact Name:	**Relationship to patient:**	**Home/cell phone:** ( )	**Work phone:** ( )

INSURANCE INFORMATION

Do you have health insurance? ❑ **Yes** (Please give your insurance card to the receptionist) ❑ **No**, I'm a self-pay patient

IS THIS A WORK-RELATED INJURY OR DUE TO A MOTOR VEHICLE ACCIDENT? ❑ **Motor Vehicle** ❑ **Work Related** ❑ **No**

If yes, do you have an open claim? ❑ **Yes** ❑ **No** **Claim Number:**

Primary Insurance

Policy Holder Name:	**Insurance Company:**	
Policy Holder Birth Date:	**Policy ID Number:**	
Relationship to Patient:	**Group Number:**	
Policy Holder Employer:	***WE DO NOT PROCESS SECONDARY INSURANCES- PATIENT RESPONSIBILITY**	
Person responsible for bill:	**Address (if different):**	**Home Phone:**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the chiropractor. I understand that I am financially responsible for any balance. I also authorize Long's Chiropractic HS or insurance company to release any information required to process my claims.

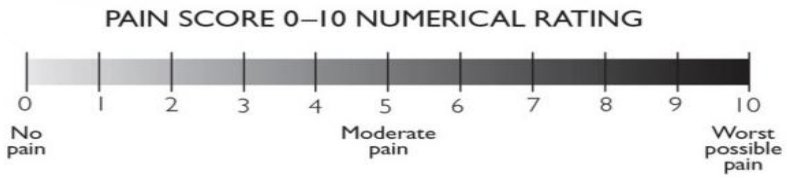
x

Patient/Guardian signature ***Date***

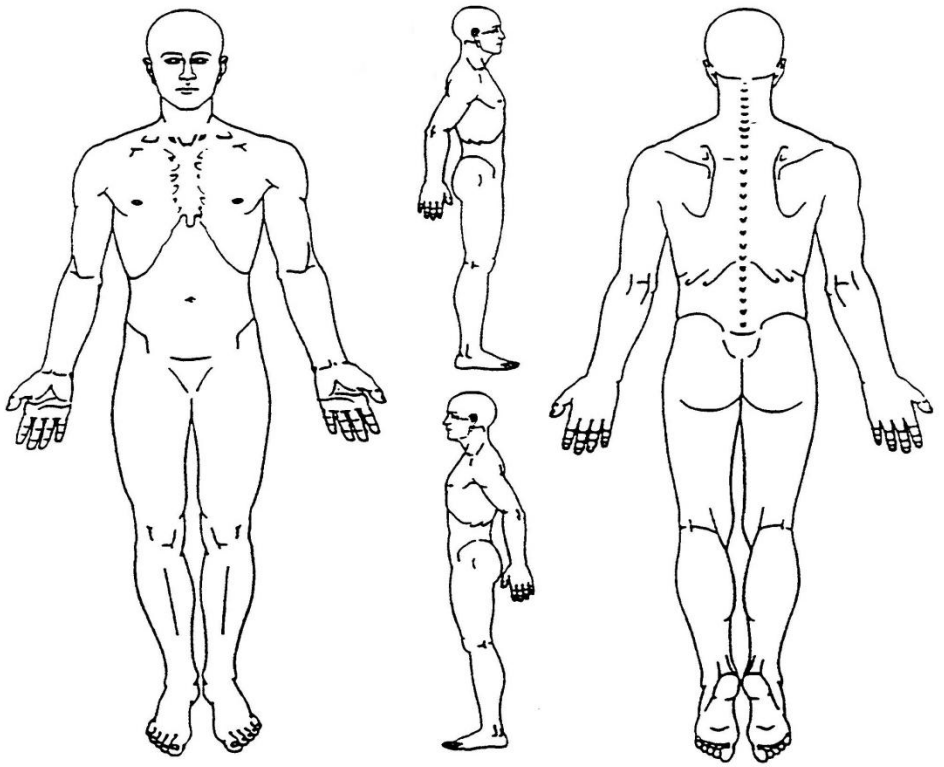
CONSENT FOR TREATMENT

I authorize the doctors of Long's Chiropractic HS and whoever they may designate as assistants to examine, perform diagnostic tests, and administer treatment as necessary. I understand that there is approximately a one in one million to ten million chance of stroke or fractured rib which may be a result of manipulative therapy. If the patient is a minor, I, as a parent or guardian, give consent for treatment to be administered.

x	
Patient/Guardian signature	**Date**

PATIENT HEALTH HISTORY
Reason for today's visit:
When did these symptoms start?
How did they start?
Does anything help decrease your symptoms?
What makes your symptoms worse?
How do your symptoms affect your daily living/work?
Do your symptoms wake you from sleep? ❑ **Yes** ❑ **No**
Using the following scale please mark an "X" or circle your current level of pain: 
Using the same scale how would you rate your symptoms at their best? _____ At their worst? _____
Before today have you seen another provider for this issue?
Are you currently receiving any other treatment for this condition/injury? ❑ **Yes** ❑ **No**
If yes, please explain:

Please mark any area(s) of discomfort with the following:



A = Ache

B = Burning

N = Numbness

↑ or ↓= Radiating/Shooting

/ = Sharp

S = Stiffness

+ = Throbbing

T = Tingling

O = Other

SOCIAL HISTORY	
Do you currently use tobacco products? ❑ Yes ❑ No	**Products used, amount, and frequency:**
Have you previously used tobacco products? ❑ Yes ❑ No	**For how long?**
Do you drink alcohol? ❑ Yes ❑ No	**Frequency and amount:**
How often do you use recreational drugs? ❑ Never ❑ Sometimes ❑ Frequently	
How many hours of sleep do you get per day/night on average?	
How would you rate your current stress level? ❑ Low ❑ Moderate ❑ High	
Do you exercise on a regular basis? ❑ Yes ❑ No	**If yes, how often:**
What types of exercise(s) do you perform?	

MEDICAL HISTORY

Please check any of the following conditions that you or an immediate family member has/had:

Condition	Self	Family	Condition	Self	Family
Alcohol/drug abuse			Hepatitis		
Anemia			High blood pressure		
Arthritis			High cholesterol		
Artificial Joints			Hyper/hypothyroid		
Cancer			Kidney problems		
Chest pain			Low blood sugar		
Diabetes			Low back pain		
Difficulty swallowing			Neck pain		
Digestive disorders			Osteoporosis		
Dizziness/vertigo			Menopause symptoms		
Dysmenorrhea			Mid-back pain		
Emphysema			Muscle cramping/spasm		
Fatigue			PMS		
Gout			Recent changes in vision		
Extremity pain (arms/legs)			Seizures/Epilepsy		
Headaches			Sleep problems		
Heart disease			**Stroke**		
Heart attack			Unusual bleeding		

Other conditions not listed above:

MEDICAL HISTORY CONTINUED	
DO YOU HAVE A PACEMAKER? ❑ Yes ❑ No	**KNOWN TUMORS?** ❑ Yes **Location of tumor(s)**_____ ❑ No
Please list any previous surgeries, major falls, head injuries, broken bones, joint dislocations, hospitalizations, or imaging (x-rays, MRI, CT scans, etc.) to any of the areas you wish to be treated today:	

MEDICATIONS AND SUPPLEMENTS		
Please list any known food or environmental ALLERGIES:		
Please list any current medications (over-the-counter or prescription), supplements (vitamins/minerals), or herbs that you are currently taking:		
Name of medication/supplement	**Dosage and Frequency**	**Reason for taking medication/supplement**
Are there any other symptoms of concerns about your current conditions that have not been covered to this point that you would like to address?		

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INFORMED CONSENT

CHIROPRACTIC

CONSENT FOR USE/DISCLOSURE OF HEALTH INFORMATION

I acknowledge that I have received and read my copy of Long's Chiropractic Health Service's Notice of Privacy Practices (act 164.520) before signing this consent for use and disclosure of my personal health information. I agree to the terms of Long's Chiropractic Health Services Notice of Privacy Practices and authorize Long's Chiropractic Health Services to use and disclose my personal health information as described in their Notice of Privacy Practices.

_____ _____
Printed Name of Patient/Parent/Guardian (if applicable) Patient/Parent/Guardian Signature

_____ _____
Printed Name of Minor (if applicable) Date

_____ _____
Witness Signature Date

DIAGNOSIS (FOR OFFICE USE ONLY)

TREATMENT PLAN (FOR OFFICE USE ONLY)

CMT: Diversified Flexion/Distraction Traction Drop Activator to restricted regions : Cervical Thoracic Lumbar Sacrum Extremity_____	**_____ treatments/week for _____ weeks, based on patient progress**
Moist Heat to : Cervical Thoracic Lumbar Sacrum	**For 15 minutes with 4 towel layers**
Cryotherapy to: Cervical Thoracic Lumbar Sacrum	**For 15 minutes**
Electric Stimulation to: Cervical Thoracic Lumbar Sacrum	**For 10 minutes with one towel layer**
Ultrasound: : Cervical Thoracic Lumbar Sacrum	
Therapeutic exercise/stretching	**For 15 minutes total**
Soft tissue manipulation to listed taut tender muscles	**5 minutes of Manual/ConnecTX**
Kinesiology tape (according to Rock Tape specifications)	
Therapeutic exercise/at home exercises:	

INFORMED CONSENT

I,_____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of **manipulations/adjustments involving movement of the joints and soft tissues of the spine and extremities. Therapeutic exercises, stretches, and adjunct procedures may also be used.** Although spinal manipulation (adjustment) is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

-**Soreness**: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

-**Dizziness**: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

-**Physical Therapy Burns**: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

-**Fractures/Joint Injury:** I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

-**Stroke**: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises, and possible surgery.

-**Medications:** Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

-**Rest/Exercise**: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bedrest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

-**Surgery**: Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

-**Non-treatment**: I understand the potential risks of refusing or neglecting care may include increases pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment:

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

Doctor Signature Date

CHIROPRACTIC APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your chiropractic care to Long's Chiropractic Health Services. When you schedule an appointment with us, we schedule enough time to provide you with the highest quality care for each visit. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and **no later than 24 hours prior to your scheduled appointment time**. This gives us enough time to schedule other patients who may be waiting for an appointment. If you fail to notify the office that you are unable to make an appointment at least 24 hours before your appointment time you will be subjected to the cancellation/no show fee. Our appointment cancellation/no show policy is effective July 5, 2021 and is outlined below:

- First offense: any established patient who fails to show at their appointment or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours' notice** before their scheduled appointment time will be considered a "No Show" and will be charged a **$25 fee**.
- Second offense: any established patient who fails to show at their appointment or cancels/reschedules an appointment with **less than 24 hours' notice** a second time will be charged a **$40 fee**.
- Third offense: any established patient who fails to show at their appointment or cancels/reschedules an appointment with **less than 24 hours' notice** a third time will be charged **$40 fee and will be required to pre-pay for any future visits** when scheduling an appointment. The providers reserve the right to release a patient from care after a third late cancellation/no show incident.
- Any new patient that fails to show at their initial appointment without notice **will not be rescheduled**.
- **The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.**
- As a courtesy the office scheduling system sends out reminder texts/e-mails (when patients have opted in to text/e-mail alerts) the day before any scheduled appointments. If you for some reason do not receive a reminder text/e-mail the above policy still remains in effect. Please do not respond to the reminder text/e-mail if you are unable to make your appointment; these are automated messages sent from our scheduling software and responses cannot be checked.

We understand that there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please call our office at (717) 394-6558 and the doctors may waive the No Show fee.

I HAVE READ AND UNDERSTAND THE CHIROPRACTIC APPOINTMENT CANCELLATION/NO SHOW POLICY AND AGREE TO ITS TERMS.

_____	_____
Signature (Patient/Parent/Legal Guardian)	**Relationship to Patient (other than self)**
_____	_____
Printed Name	**Date**

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A. Notifier: Long's Chiropractic Health Services

B. Patient Name: **C: Identification Number:**

Advance Beneficiary Notice of Non-Coverage (ABN)

NOTE: If your insurance doesn't pay for **D. (Exam/Treatment)** below, you may have to pay. Your insurance may not offer coverage for the following services even though your health care provider advises these services are medically necessary and justified for your diagnoses. It is possible that your insurance company may not pay for the **D. (Exam/Treatment)** below.

D. Treatment	E. Reason Insurance May Not Pay:	F. Estimated Cost
New Patient Exam	-May be considered a non-medical necessity, may not be a covered service under certain insurances (ex: Medicare), or not covered until deductible is met	$50-70
Chiropractic Manipulation	-May be considered a non-medical necessity (maintenance) or not covered until deductible is met -May not be covered for certain age groups (children)	$40-50
Passive Care (including therapeutic exercises, soft tissue mobilization, electric stim., stretches, etc.)	-May be considered a non-medical necessity, not covered until deductible is met, or insurance may limit passive care services -May not be a covered service under certain insurances (ex: Medicare)	$10-30

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. (Exam/Treatment)** listed above.

G. Options: Check only one box. We cannot choose a box for you.

□ **OPTION 1.** I want the **D. (Exam/Treatment)** listed above. You may ask to be paid now, but I also want my insurance billed for an official decision on payment, which is sent to me as an Explanation of Benefits. I understand that if my insurance doesn't pay, I am responsible for payment, but I can appeal to my insurance. If my insurance does pay, you will refund me any payments I made to you, less co-pays or deductibles.

□ **OPTION 2.** I want the **D. (Exam/Treatment)** listed above, but do not bill my insurance. You may be asked to be paid now as I am responsible for payment.

□ **OPTION 3.** I don't want the **D. (Exam/Treatment)** listed above. I understand that with this choice I am **not** responsible for payment, and I will not be treated today.

H. Additional Information: This notice gives our opinion on potential responses from insurance, it is not a denial from your insurance company. If you have other questions on this notice please ask the receptionist, the billing associate, or the physician before you sign below. Signing below means that you have received and understand this notice. You are entitled to a copy of this document upon your request.

I. Signature of Patient (over 18) or Parent/Guardian:	J. Date: