Apex Chiropractic
21 Putnam Pike
Dayville, CT 06241
(860)932-0550

PATIENT INTAKE

Welcome to our online intake form. The information you fill in will be sent directly to our office, speeding up your office visit and allowing us to better serve your healthcare needs.

ABOUT YOU

1. First Name: _____ Last Name: _____ DOB: _____

2. Home Address

Address 1 _____ Address 2 _____

City _____ State _____ Zip Code _____

3. Contact Information

Mobile Phone _____ Home Phone _____

Primary Email Address _____

4. Demographic Information

Sex at birth:
○ Male ○ Female

Marital Status:
○ Single ○ Married ○ Divorced ○ Widowed ○ Minor ○ Other

5. Emergency Contact Information

Emergency Contact Name: _____ Contact Phone Number: _____ Relationship to Patient: _____

6. Personal Information

Height - Feet: _____ Height - Inches: _____

Weight (in pounds): _____

7. Referral Information

How did you hear about us?

○ Word of mouth ○ Advertisement ○ Social media ○ Direct mail or email campaign ○ Event ○ Internet

Referring Physician: _____ Referring Patient: _____

Other: _____

8. Do you have insurance?

○ Yes

○ No

9. Insurance Payer

Insurance Payer _____

10. Insurance Policy Information:

Insurance Plan Name _____ ID/Policy Number: _____ Group Number: _____

Relationship to Patient:

○ Self ○ Spouse ○ Parent ○ Employer ○ Caregiver ○ Other

Insured's First & Last Name: _____ Insured's Date of Birth: _____

11. Employer Information

Employment Status:

○ Employed ○ Student ○ Not Employed ○ Retired ○ Unknown

Employer Name: _____ Occupation: _____

Physical Work Duties: _____

Does your job effect your symptoms? _____

VISIT PURPOSE

12. Select the main reason for this visit:

○ Complaint ○ Auto Accident

○ Work injury ○ Injury

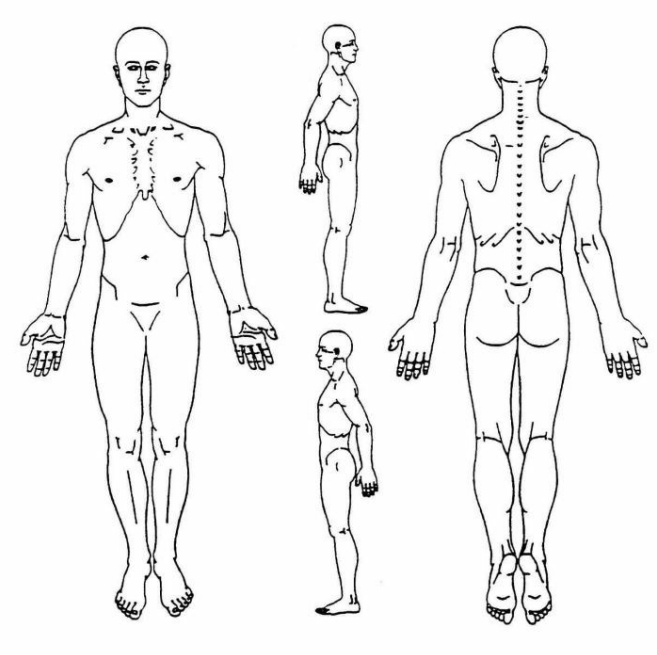
○ Wellness

AREAS OF CONCERN

13. Approximate date this condition began (exact date not required)

What caused this condition? (mechanism of injury)

14. Where is your pain located?



15. What term(s) describes your discomfort? Choose all that apply.

	Yes	No
Aching		
Burning		
Deep		
Dull		
Intolerable		
Sharp		
Shooting		
Stabbing/Throbbing		
Stiffness		
Tightness		
Tingling		
Other		

If other, specify:

16. Rate the severity of your discomfort at its worst, on a scale of 0 – 10 where 0 is no pain and 10 is severe pain

How often do you feel this discomfort?

How has this complaint changed since onset?

17. List anything that aggravates your condition.

If other,specify:

18. Lists anything that improves your condition or gives you relief.

If other, specify:

19. Have other health care provider(s) performed tests related to this condition?

- Yes
- No

If Yes, specify:

20. Have you ever had any previous episodes of this condition?

- Yes
- No

If Yes, specify:

21. Do you have an additional condition?

- Yes
- No

CURRENT HEALTH

22. Have you had previous chiropractic care?

- Yes

○ No

Conditions treated:

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23. Please list regularly used prescription and over-the-counter medications taken, as well as the Dosage and Frequency for each medication (e.g. 5 mg once daily)

	Medication Name	Dosage/Frequency
1		
2		
3		

24. Medication Allergies

	Medication Name	Reaction	Onset Date	Additional Comments
1				
2				
3				

25. Other than the condition(s) already shared, do you have any additional health concerns?

	Yes	No
Muscles, Bones or Joints		
Nerves, Headaches, Dizziness, or Emotional		
Head, Eyes, Ears, Nose or Throat		
Heart, Blood Pressure, or Circulation		
Shortness of Breath, Coughing, Asthma or Lung Condition		
Stomach, Bowels or Digestive Conditions		
Genital, Bladder, or Urinary Conditions		
Diabetes, Thyroid or Glandular Condition		
Skin or Blood Conditions		

Please list conditions:

PERSONAL AND FAMILY HISTORY

26.

	Yes	No
Have you had any surgical procedures?		

Are there any past illnesses or conditions we should be aware of?		
Do you have a past history of accidents or trauma?		
Do you have a past family illness history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of?		

27. Current work habits - Choose all that apply.
☐ Permanently fully disabled ☐ Permanently partially disabled ☐ Cannot work due to current condition
☐ Full-time (20-40+ hours/week) ☐ Part-time (1-19 hours/week) ☐ Retired ☐ Student ☐ Homemaker
☐ Unemployed

AUTO ACCIDENT -- Only Complete if applicable

28. When did the accident occur?

Where in the vehicle were you at the time of the accident?

In what direction were you looking at the time of impact?

29.

	Yes	No/Unsure
Were you wearing a seatbelt?		
Did the airbag deploy?		
Did you come in contact with anything at the time of the collision?		
Did you receive an injury to the head?		
Did you lose consciousness?		
Did your head hit the headrest?		

30. Which part of your vehicle was impacted? Choose all that apply.

	Yes	No
Front right		
Front left		
Front head on		
Rear end- center		
Rear right		
Rear left		
Right side (passenger's side)		
Left side (driver's side)		
Unknown		

31. In what direction was your vehicle moving?

What was the extent of the damage to your vehicle?

In what direction was the other vehicle moving?

What was the extent of the damage to the other vehicle?

32.

	Yes	No
Was your vehicle towed from the scene?		
Did police arrive at the scene?		
Was an accident report taken?		
Did Emergency Medical Services arrive at the scene?		

33. How did you leave the scene of the accident?

34. Where was discomfort felt immediately following the accident? Choose all that apply.

	Yes	No
Abdomen		
Back		
Chest		
Face		
Head		
Neck		
Right shoulder, elbow, arm or hand		
Left shoulder, elbow, arm or hand		
Right hip, thigh, knee, leg or foot		
Left hip, thigh, knee, leg or foot		
Other		

35. Are you working with an attorney?

- ○ Yes
- ○ No

Name of attorney:

WORK INJURY - only complete if applicable

36. When did the accident occur?

What type of accident caused your injury?
☐ Bending ☐ Carrying ☐ Climbing ☐ Crawling ☐ Jumping ☐ Kneeling ☐ Lying down ☐ Lifting
☐ Pulling ☐ Pushing ☐ Raising arm(s) above shoulder(s) ☐ Running ☐ Performing repetitive motions
☐ Sitting ☐ Squatting ☐ Prolonged Standing ☐ Talking on the phone ☐ Traveling ☐ Turning
☐ Twisting ☐ Typing ☐ Using a computer ☐ Walking ☐ Other job related activity
☐ Other non-job related activity

37.

	Yes	No
Did you receive an injury to the head?		
Did you lose consciousness?		
Did police arrive at the scene?		
Was an accident report taken?		
Did Emergency Medical Services arrive at the scene?		

38. How did you leave the scene of the accident?

39. Where was discomfort felt immediately following the accident? Choose all that apply.

	Yes	No
Abdomen		
Back		
Chest		
Face		
Head		
Neck		
Right shoulder, elbow, arm or hand		
Left shoulder, elbow, arm or hand		
Right hip, thigh, knee, leg or foot		
Left hip, thigh, knee, leg or foot		

40. What treatment, if any, have you received since the injury? Choose all that apply.

	Yes	No
Chiropractic care		

Massage		
Medical injection treatment		
Surgical treatment		
Over-the-counter medications		
Prescribed medications		
Natural or holistic treatment		
Acupuncture		
Physical therapy		
None		
Other		

If other, specify:

_____

Authorization: By signing, I authorize that I am the patient or legal guardian listed above. I have read/understand the included information and certify it to be true to the best of my knowledge. I consent to the collection and use of the above information to Apex Chiropractic. I authorize Apex Chiropractic and it's staff to examine and treat my condition(s) as the doctor sees fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. I understand and agree that health/accident insurance polices between an insurance carrier and myself. I understand that the fees for professional services will become immediately due upon suspension or termination of my care or treatment. I agree with this statement of authorization.

_____ _____

Signature Date

HIPAA Notice of Privacy Practices

Apex Chiropractic, LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

If you have any questions about the above notice, please contact our Office at

Our Obligations

We are required by law to:

- Maintain the privacy of protected health information
- Give you the notice of your legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

How We May Use and Disclose Health Information

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes,
we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practice's
privacy officer.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services. We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health
related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

Special Situations

As required by law. We will disclose Health Information when required to do so by international, federal, state, or

local law.

To Avert a Serious Threat to Health of Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation.

Military and Veterans. If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Worker's Compensation. We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit of a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6)in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Protective Services and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

Your Rights

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have the right to inspect and copy Health Information that we may used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

Changes to This Notice

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

Complaints

If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

By Subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

_____ _____

Patient Signature Date

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. 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 known, is my best interest.

I have read, and or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

To be completed by patient:

_____
Print Patient's Name

_____
Signature of Patient

_____
Date Signed

To be completed by doctor or staff:

Name and address of clinic/office: Print name (s) doctor (s) treating this patient:

Apex Chiropractic, LLC

Office Name: Apex Chiropractic, LLC

Office Address: 21 Putnam

Patient Messaging Consent

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or other communications via an automated outreach and messaging system. I also authorize my healthcare provider to disclose to third parties who may intercept these messages (individuals you have provided with access to your digital devices or email accounts) limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from the automated outreach and messaging system, when necessary.

Patient Name

Date

Patient Signature

CANCELLATION & MISSED APPOINTMENT POLICY

Our goal at Apex Chiropractic is to provide you with convenient, accessible, high quality medical care. In order for us to assure convenience and accessibility to all of our patients, it is important that patients arrive in a timely manner for all scheduled appointments or cancel the appointment at least 24 hours in advance. This policy allows us to make better use of our available appointment times for those patients in need of our care.

Cancellation of an Appointment

You may cancel your scheduled appointment by calling our office during regular business hours. Outside of regular business hours, please leave a voice mail if cancellation of an appointment is necessary. Appointments are in high demand and your early cancellation will give another patient the opportunity to be seen by a provider.

Missed Appointment Policy

A “missed appointment” is the occurrence where someone does not present for an appointment and does not cancel the appointment at least 24 hours in advance. If you do not show up for your appointment and you do not cancel the appointment 24 hours in advance, we will record this in your medical record as a "missed appointment".

Fees for Appointments – Financial Agreement

Effective March 24, 2023, Apex Chiropractic will charge patients when they do not present for scheduled appointments. Failure to cancel or re-schedule the appointment within 24 hours of the scheduled appointment time will result in a fee for a missed appointment. This fee will not be submitted to the health plan; it will be charged directly to the patient. We understand that flexibility is important and patients may be allowed one “free” missed appointment charge. The missed appointment fee structure is **$25** for an existing patient appointment and **$50** for a new patient appointment. The added cost is due to the added time committed to new patient appointments.

I acknowledge that I have read and understand the above policy statement regarding fees for missed appointments. I understand I will be held financially responsible if there is a violation of this policy. I may also contact the office at (860)932-0550 for additional information.

Please note: Repeated "missed appointments" may result in discharge from the practice.

_____

Print Patient Name

_____

Patient Signature (Parent or Guardian Signature if Patient is under 18)