Island
Chiropractic Centre
Dr. Anthony C. Ross

Today's Date_______/______/_____________

NEW PATIENT INTAKE

Name____Date of Birth _______/______/____________

Social Security Number_________________________ Sex: M F Pregnant: Y N Marital Status: S M D W

Address____ City_________________________ State_____________ Zip_____________

Phone: Cell (______)________________________ Business (______)____________________ Home (______)________________________

E-mail ___________________________________ Occupation _______________________Employer_____________________________

Spouse: (Name______________________________ DOB ______/_____/_______ Employer_____________________________________

Past Chiropractic Care: Y N if Yes, When? __________________ Chiropractor's Name_______________________________

Medical Doctor______________________________________ Referring Doctor____

Emergency Contact Name:________________________________ Phone:____________________ Relationship:_________________

If you were referred to Dr. Ross, we would like to thank them. Please provide their name____

Medical Insurance Information

Subscriber's Name: ____

Address: ____

City: ___________________________ State:_______________ Zip:_________________

Subscriber's Date of Birth: __________________________ Relationship to Subscriber: ___________________

Are you now or have you ever been disabled? (Service or Work)? [ ] NO [ ] YES When? ______________________________________

Is your present condition due to an injury? [ ] NO [ ] YES [ ] On the job [ ] Auto Accident [ ] Personal Injury [ ] Other_______________
Accident Date: ____________________

Attorney Name: ____________________________________ Auto Insurance Carrier: ____________________________________

Have you sustained any recent fractures anywhere? Y N Describe:____

List all fractures sustained previously:

Bone name of body area	Date	Bone name or body area	Date
1.____________________________	______________	3.____________________________	______________
2.____________________________	______________	4.____________________________	______________

If there is any additional information that you think would be relevant for us to ensure better personal healthcare quality, please include it in the following space

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Update Patient Information

We are in the process of updating our records to comply with federal standards, please answer the following questions:

Name: ______________________________

Preferred Language?

- ☐ English
- ☐ Spanish
- ☐ Other____________________

Height: _____ feet _____ inches

Weight: ________ lbs

Race?

- ☐ I do not wish to provide this information.
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other ____________________

Ethnicity?

- ☐ I do not wish to provide this information.
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Non-Latino
- ☐ Other ____________________

Smoking Status?

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoker

Do you have any medication allergies?

- ☐ No known medication allergies
- ☐ Yes. What? ____

Are you currently taking any medications?

- ☐ Not currently prescribed any medications
- ☐ Yes...

What? _________________________ ______ mg

What? _________________________ ______ mg

What? _________________________ ______ mg

Authorization

- **PAYMENT IS EXPECTED AT TIME OF VISIT.** Are you insured? ☐ YES ☐ NO
  Company ______________________ Policy Holder's Name____________________
  Date of Birth____________ Employer____________________ ID #___________
- I authorize payments to Island Chiropractic Centre by my insurance company for all services rendered to me or to my dependants.
- I authorize the physician to release any information required for my chiropractic care or for insurance purposes as outlined in the Notice of Privacy Policies and Practices that is in the reception area for my viewing.
- I authorize use of this signature on all insurance submissions.
- I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Any amount authorized to be paid directly to Island Chiropractic Centre will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I also understand that I am responsible for payment for services rendered if my insurance company deems the provided services not medically necessary despite being clinically appropriate. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I also understand that if I am accepted as a patient by the physicians of Island Chiropractic Centre, I am providing authorization for them to proceed with any treatment that may be necessary. Furthermore, any risks regarding chiropractic treatment will be explained to me upon my request and are outlined in the "Informed Consent to Treat" that I will receive. The doctor will not be responsible for any pre-existing medical conditions nor for any medical diagnosis.

Patient/Guardian Signature________________________________ **Date**__________

- DISCLOSURE POLICY FOR EDUCATION
  All digital photographs or x-rays taken of me may be reproduced for educational purposes. Island Chiropractic Centre has my authorization to use this information to educate current and future patients of the vitality of chiropractic care. I understand that this information will only be disclosed in an educational and anonymous form. I also understand that I, the patient, have the right to inspect the health information to be utilized. I understand that treatment will not be refused to me if I do not authorize the Disclosure Policy for Education. My consent will expire ten years subsequent to the date of signature. I have the right to revoke my consent in writing.

Patient/Guardian Signature________________________________ **Date**__________

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before your sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to it terms. I am also acknowledging that I have received a copy of this notice.

____________________	____________________
Printed Name	Authorized Provider Representative
____________________	____________________
Signature	Date
____________________	
Date	

THE SOUTH CAROLINA CHIROPRACTIC ASSOCIATION

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Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

This notice is effective as of ____________________. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

Patient name printed	Date
Patient Signature	Authorized provider representative
Personal representative Printed	Personal representative signature

Description of personal representative's authority to act for the patient.

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Dr. Anthony Ross
Island Chiropractic Centre

Patient Privacy Notice Acknowledgement

This notice is effective as of____________________. This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that the Privacy Policy of this office is available for my inspection in the reception area. May change without notice.

____________________	____________________
Pt name printed	Date
____________________	____________________
Pt signature	Authorized provider rep.
____________________	____________________
Personal rep. printed	Personal rep. signature

Description of personal representatives authority to act for this patient.