PATIENT INTAKE FORM

WELCOME and THANK YOU for choosing our office. We are committed to helping you reach your health and wellness potential. At SLO Wellness Center we believe in whole person health. First through role modeling, and second through teaching, we are passionate about motivating our patients and the community to *Eat Well, Move Well, and Be Well.*

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PATIENT DEMOGRAPHICS

First Name:_____ **Last Name**:_____**MI**:_____ **Preferred Name**:_____

Sex at Birth: _____ Pronouns:_____**DOB**:____/____/____ **Age**:_____ **SSN**:_____/ _____/_____

Mailing Address:_____ **City**:_____ **State**:_____ **Zip**:_____

Preferred Language _____Email:_____

Home Phone:_____ **Cell Phone**:_____ **Marital Status:**_____

Employer:_____ **Occupation:**_____ **Phone**:_____

Emergency Contact:_____**Relationship**:_____**Phone**:_____

Who can we thank for referring you in?_____
Relationship:_____

HEALTH AND WELLNESS

Please rate between 1-10 with "1" being the lowest where you feel like your health is in each of the categories below:

1.) EXERCISE: _____

Do you exercise? □Yes □No **How often?** □1X □2X □3X □4X □5X per week **Other:** _____

What activities? □ Running □Jogging □Weight Training □Cycling □Yoga □Pilates □Swimming **Other:**_____

2.) DIET: _____

My diet consists of: □Fruits □Vegetables □Chicken □Beef □Fish □Fast Foods □Soda

Do you drink alcohol? □Yes □No **How much?**_____ **Do you drink coffee?** □Yes □No **How much?**_____

Smoking Status: Do you smoke? □Yes □No If so, what and how much per day? _____

3.) SLEEP: _____

4.) STRESS MANAGEMENT: _____

What other forms of health care do you use? □Acupuncture □Massage Other:_____

Are you currently taking any supplements (i.e. vitamins, supplements, herbs)?

Supplement Name	Dosage and Frequency

Please list your health and wellness related goals:

Physical Goals	Nutritional/ Biochemical Goals	Psychological Goals

PURPOSE OF VISIT

Reason for this visit (main complaint): _____

Is this a result of a work injury / auto accident? □Yes □No **If so when:**_____

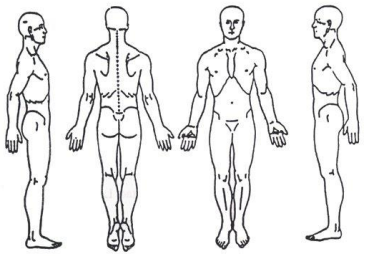
When did this condition begin? _____/_____/_____ **Did it begin:** □Gradual □Sudden □Progressive over time

Is there anything that relieves your symptoms? _____ **Have you experienced this before?** □Yes □No

Is the problem interfering with your work, sleep, daily routine?: □Yes □No
If so, please describe:_____
Have you sought any other treatment before this?: □Yes □No
If so, please describe:_____
Who is your primary treating physician? (MD)_____

Have you ever seen a chiropractor before? □Yes □No **If so whom**:_____ **Where**:_____
Are you pregnant? □Yes □No **Are you breast feeding?** □Yes □No

Please show us where you are experiencing pain and/or discomfort by putting circling the body:



MEDICAL CONDITIONS

Are you currently taking any medications? (please include regualry used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Family Medical History (Record one diagnosis in your family history and the affected)

Diagnosis: (write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease		*X*		

Please list any other serious medical conditions you have or ever had:

Medical Condition	Surgeries	Serious Accident / Trauma
1._____	1._____	1._____
2._____	2._____	2._____
3._____	3._____	3._____

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FINANCIAL OPTIONS

SLO Wellness Center is a Patient Centered Practice. We provide care based on a patients desire to obtain optimum health. We also offer simple solutions for understanding and using your insurance benefits. Please follow the flow chart below to understand more about your specific insurance benefits.

INSURANCE	
In Network Insurance	**Out of Network Insurance**
Blue Shield PPO United Health Care Multi Plan Marian (dignity health)	*Blue Cross Aetna Cigna Health Net Medicare All HMO Plans & Blue Shield ASHP
As a courtesy we will bill your insurance for your treatment	
Deductible: _____ Left: _____ Estimated copay/co-insurance:_____ Visits (Per Year): _____ Estimated Initial Visit: $88 -$125 Estimated Follow up Visit: $52	Deductible:_____ Left:_____ Initial Visit: $170 Follow up visits: $70 Your plan covers:_____ Visits (per year):_____ *Blue Shield, Blue Cross SISC, PG&E or Anthem plans managed by ASHP allow 5 visits per year
*If your deductible is met, it will be your responsibility to pay your copay or co-insurance at time of service **	*If your plan has out of network benefits, any reimbursement for treatment will come directly to you**

NO INSURANCE	
Initial Visit: $170	**Follow up Visit: $70**
Please inquire about our package rates or family plans and check with your doctor to see what would be the best option for your treatment plan.	

Please initial below:

____ There is a $5.00 late fee for all unpaid bills over 30 days

____ There is a $25.00 fee for missed appointments and those not cancelled 24 hours in advance

____ I understand that SWC can bill my insurance as a courtesy and that I am ultimately responsible for my payment of services provided.

Signature_____ Date_____

**In order to receive insurance benefits, the member must be covered at the time of service.*

The amounts above are only estimates; we will know the exact amount when we receive the explanation of benefits from your insurance. As quoted by your insurance company, this is not a guarantee of payment or coverage. This information does not pre-authorize payment. Benefits are subject to change. Other terms and limitations may apply even though such provisions are not indicated on your insurance company's web site. All claims are subject to medical review according to the information submitted by the provider of the service and are subject to benefit maximums and other terms of the member's contract. Please refer to the applicable benefit agreements to determine the appropriate payment amounts and any limitations or exclusions. If this is HMO coverage, benefits must be authorized by the member's assigned medical group.

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CONSENT FOR BILLING AND TREATMENT

PLEASE READ CAREFULLY AND INITIAL EACH SECTION

SLO Wellness Center (SWC) is a partnership between Stevens Chiropractic Inc., Sachs Chiropractic Inc., and Casparian Chiropractic Inc. SWC invites you to discuss with us any questions regarding your care and our services.

____ I consent to the performance of chiropractic adjustments and other chiropractic procedures by SWC D.C.'s including: Dr. Sandy Sachs, Dr. Aram Casparian, Dr. Carlos Marin and Dr. David Johnson as well as authorize SWC and whomever they designate to administer treatment as they deem necessary.

____ I authorize my provider(s) and/or managed care organization to release my information to provide other health care providers with information related to my care as well as to process insurance claims.

____ I have read, or have had read to me, the above consent. By signing below I agree to chiropractic services and intend this consent form to cover the entire course of treatment for my present condition(s) and for any further condition(s) for which I seek treatment in this office.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with the opportunity to review a Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of SLO Wellness Center health care operations. The Notice of Privacy Practices also describes my rights, SLO Wellness Center duties with respect to my protected health information. The Notice of Privacy Practices is posted by the front desk.

SLO Wellness Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

SLO Wellness Center may need to use my name, address, phone number, and my clinical record to contact me with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to me. If this contact is made by phone and I am not at home, a message will be left on my answering machine. By signing this form, I am giving SLO Wellness Center authorization to contact me with these reminders and information.

Patient Name:_____ Patient Signature:_____ Date:_____

If patient is under 18 years of age

Legal Guardian Name:_____ Legal Guardian Signature:_____ Date:_____

For Office Use Only

Witness Name (office staff):_____ Witness Signature:_____ Date:_____

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INFORMED CONSENT FOR CHIROPRACTIC CARE

PLEASE READ CAREFULLY AND SIGN BELOW

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name:_____ Patient Signature:_____ Date:_____

If patient is under 18 years of age

Legal Guardian Name:_____ Legal Guardian Signature:_____ Date:_____

Witness Name (office staff):_____ Witness Signature:_____ Date:_____

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