Bella Vita Chiropractic & Wellness

610 Eastbury Drive Suite 3 Iowa City, IA 52245 (319)887.6992

Patient Intake Form

Date:_____/_____/_____

First Name: _____Middle Initial: _____Last Name:_____

Address:_____

City:_____ State:_____ Zip Code: _____

Primary Phone: (_____)_____-_____ Secondary Phone: (_____)_____-_____

Email:_____

Date of Birth:_____/_____/_____ Sex: ☐Female ☐Male ☐Other SSN:_____

(Used for insurance billing only)

Marital Status:_____ Employment Status:_____

Emergency Contact Information:

Contact Name:_____

Relationship to patient:_____ Phone: (_____)_____-_____

Insurance Policy Holder's Data: (if different from info above)

First Name:_____ Middle Initial:_____ Last Name:_____

Date of Birth:_____/_____/_____ Address:_____

City:_____ State:_____ Zip Code: _____

Physician Information: (We will never contact your Physician without prior authorization.)

Physician's Name: _____ Contact Phone: (_____)_____-_____

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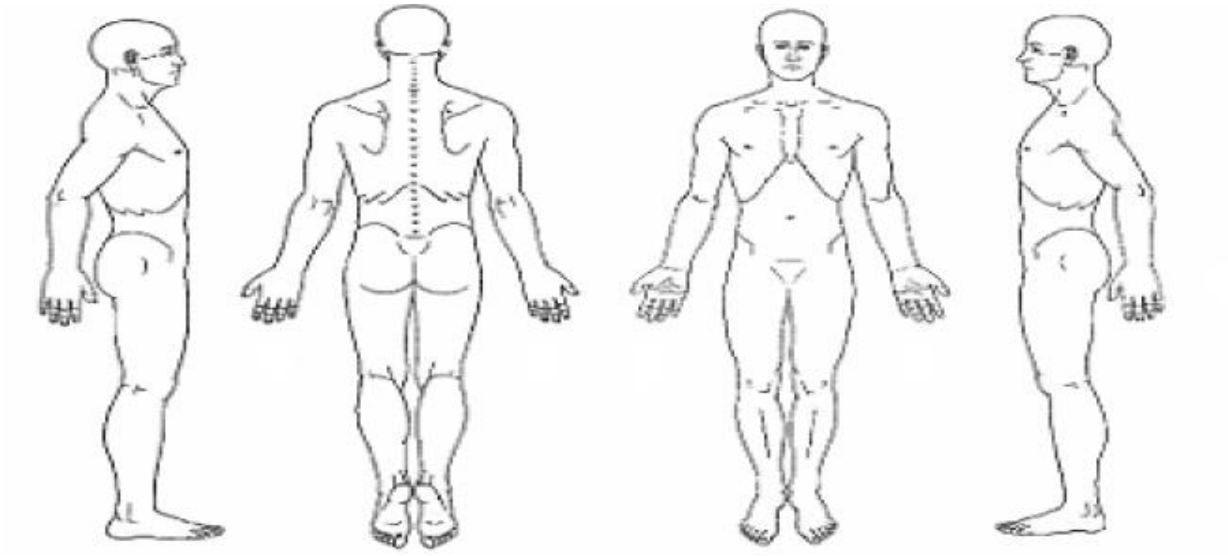
By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

= Numbness X = Burning / = Stabbing 0 = Pins & Needles + = Dull Ache ▲ = Tightness



Describe your symptoms:_____

_____

When did your symptoms start? Month_____Day_____Year_____

How did your symptoms begin? _____

Please list your current medications and/or supplements:

_____ _____ _____

_____ _____ _____

_____ _____ _____

How did you hear about our clinic? Or who referred you? _____

Medical Conditions:

☐ Arthritis ☐ Diabetes ☐Hypertension ☐ Skin Disorder

☐ Cancer ☐Heart Disease ☐ Psychiatric Illness ☐ Stroke

☐ Other:_____

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Surgeries: (Please include dates)

_____ _____ _____

_____ _____ _____

Allergies:

☐ Eggs ☐ Milk/Lactose ☐ Sulfites

☐ Fish/Shellfish ☐ Peanut ☐Wheat/Gluten

☐ Latex ☐ Soy ☐ Other:_____

Social History:

☐ Caffeine used frequently ☐ Smoke/Chew tobacco never ☐ Exercise never

☐ Caffeine used often ☐ Drink alcohol frequently ☐Experience stress frequently

☐ Caffeine used never ☐ Drink alcohol often ☐ Experience stress often

☐ Smoke/Chew tobacco frequently ☐ Drink alcohol never ☐Wear seat belts always

☐ Exercise frequently ☐Wear seatbelts usually

☐ Smoke/Chew tobacco often ☐ Exercise often ☐Wear seat belts never

Family History:

☐ Arthritis (parent) ☐ Diabetes (parent) ☐ Psychiatric (parent)

☐ Arthritis (sibling) ☐ Diabetes (sibling) ☐ Psychiatric (sibling)

☐ Cancer (parent) ☐Heart problems (parent) ☐ Stroke (parent)

☐ Cancer (sibling) ☐Heart problems (sibling) ☐ Stroke (sibling)

☐ Cholesterol (parent) ☐High Blood Pressure (parent) ☐ Thyroid (parent)

☐ Cholesterol (sibling) ☐High Blood Pressure (sibling) ☐ Thyroid (sibling)

☐ Other:_____

Children:

☐ Male under 6 years ☐ Male under 10 years ☐ Male under 19 years

☐ Female under 6 years ☐ Female under 10 years ☐ Female under 19 years

Occupational Activities:

☐ Administration	☐ Daycare/childcare	☐ Manual labor
☐ Business owner	☐ Executive/legal	☐ Home services
☐ Clerical/secretarial	☐ Food service industry	☐ Household
☐ Computer user	☐ Health care	☐ Manufacturing
☐ Construction	☐ Heavy equipment operator	

☐ Other:_____

Please circle any of the following additional topics you would like to discuss with your Doctor:

Diet/Nutrition	Bloodwork
Exercises	Body Mechanics
Stretches	Weight loss
Massage Therapy	Muscle gain
Workplace Ergonomics	Other_____

Supplements:

Daily Supplements	*Pain/Inflammation*	*Women's Health*
Gut Health	*Joint/Muscle Support*	*Immunity Support*
Stress	*Other*_____	

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Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information (PHI) will be used and I agree to these policies and procedures.

_____

Name of Patient Date

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Informed Consent

The primary treatment used by doctors of chiropractic is the spinal manipulation or spinal adjustment.

The nature of the chiropractic adjustment/manipulation:
The doctor will use his/her hands or a mechanical instrument upon your body in such a way as to move your joints. This adjustment my cause an audible "pop" or "click" much like when you "crack" your knuckles. You may or may not feel or sense movement. The doctor may also choose to provide therapy including muscle massage, ultrasound, electrical muscle stimulation or cold laser therapy.

The material risks inherent in chiropractic adjustments/manipulations:
As with any healthcare procedure, there are certain effects or complications which may arise.
These complications can include fracture, disc injuries, muscle strains, cervical myelopathy (compression of the spinal cord), injuries of ribs, and soreness or stiffness after treatment. Some types of manipulation of the neck have been associated with injuries of the arteries in the neck leading to or contributing to serious complications including stroke.

The probability of risks occurring:
Fractures, disc, rib injuries, and cervical myelopathy are rare occurrences and generally result from some underlying condition or weakness. The doctor makes every attempt to become aware of these during the taking of your history and during examination. Injuries to arteries and stroke caused by chiropractic manipulation of the neck have been the subject of ongoing research and debate in the medical community. The most current research on the topic is inconclusive. There are types of manipulation that are least likely to be associated with these injuries. Upon your request the doctor will discuss these in detail. At all times the doctor will choose treatments that minimize the risk of discomfort and injury while providing the greatest benefit for your condition.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or have had read to me the above explanation of the chiropractic and adjustment and related treatment. I have discussed it with Dr. Jordan M. DeGrazia, Dr. Spencer Brink, or Dr. Maria Conley and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and I have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to receive care.

Printed Name: _____

_____

Signature Date

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Financial Policy

Chiropractic care is covered under many insurance plans. We ask that you read and understand our policy as it applies to your particular situation

PATIENTS WITHOUT INSURANCE
Bella Vita Chiropractic & Wellness, Longevity Chiropractic, and Conley Chiropractic offer a 20% Time of Service Reduction in payment for those patients without coverage. We are happy to accept cash, check, Master Card, Visa, American Express or Discover.

GROUP OR INDIVIDUAL INSURANCE
Bella Vita Chiropractic & Wellness, Longevity Chiropractic, and Conley Chiropractic are participating providers for Blue Cross Blue Shield PPO plans and several other commercial plans. Conley Chiropractic is participating provider for Blue Cross Blue Shield HMO plans. Coverage, co-payments, coinsurance and deductibles vary with each plan. We will attempt to verify your coverage and patient responsibility at the time of your visit. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Payment will be due by you at the time of service for any non-covered services, deductibles, co-pays or co-insurance. Any questions concerning your coverage may be directed to your insurance company. For those insurance plans in which we do not participate, you may want to verify if you qualify for out-of-network benefits by contacting your insurance company.

SECONDARY INSURANCE
Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

MEDICAID
Bella Vita Chiropractic & Wellness, Longevity Chiropractic, and Conley Chiropractic are not in network with Medicaid of Iowa or any other state.

"ON THE JOB" INJURY (Worker's Compensation)
Employers typically have authorized practitioners that work with their worker's compensation insurance company. You will need to contact your employer to find out their specific protocol. If Bella Vita Chiropractic & Wellness, Longevity Chiropractic, or Conley Chiropractic is approved to provide care you will need to provide us with the name and address of the insurance carrier and/or adjuster.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS
Please notify your auto insurance carrier of your visit to our office immediately. The benefits quoted by the insurance company are not a guarantee of payment. Notify our insurance department immediately of the insurance information needed for billing and if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for the settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

MEDICARE
Bella Vita Chiropractic & Wellness and Longevity Chiropractic do not accept assignment from Medicare. Any insurance reimbursement is sent directly to our patients. You are required to pay the deductible as well as the limiting charge and any non-covered services at time of service. Our office completes and files the claims for Medicare at no charge. Conley Chiropractic does accept assignment from Medicare. You are required to pay your copay each visit. Our office completes and files the claims for Medicare at no charge.

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Financial Policy

I have read and understand the payment policy of Bella Vita Chiropractic & Wellness, Longevity Chiropractic, or Conley Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Bella Vita Chiropractic & Wellness, Longevity Chiropractic or Conley Chiropractic and my insurance company.

I request that Bella Vita Chiropractic & Wellness, Longevity Chiropractic, or Conley Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days or if I suspend or terminate my schedule of care as prescribed by Dr. DeGrazia at Bella Vita Chiropractic & Wellness, Dr. Brink at Longevity Chiropractic, or Dr. Conley at Conley Chiropractic that fees will be due and payable immediately.

Printed Name: _____

_____

Signature Date