RIVER RUN CHIROPRACTIC INC.
PATRICK RYAN, DC

PATIENT INTAKE FORM

ALL INFORMATION PROVIDED WILL BE TREATED AS CONFIDENTIAL

Name _____ Birthdate _____ Age _____ Gender _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____

Email Address _____ ☐ Check box if you want to opt out of informational emails

Emergency Contact Name _____ Phone _____ Relationship _____

How did you hear about our office? _____

If you are here due to a work or car accident, stop here and alert staff. If not, complete this form.

Occupation _____ Employer _____

Height _____ Weight _____ Are you currently pregnant? ☐ Yes ☐ No

Number of children _____ Ages _____

Purpose of today's appointment: _____

Have you been treated recently for any serious health condition? ☐ Yes ☐ No

If yes, describe briefly: _____

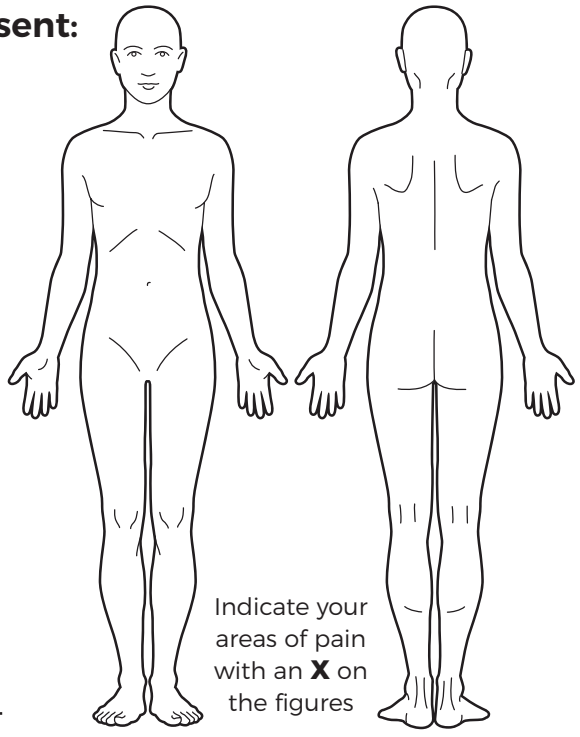
Are you under the care of a physician/other health professional? Name: _____

Have you had any previous chiropractic care? ☐ Yes ☐ No Chiropractor's name: _____

Please list any serious health conditions of **immediate** family members: _____

Please check any conditions from your past or present:

- ☐ OSTEOPOROSIS
- ☐ ARTHRITIS
- ☐ DIABETES
- ☐ HIGH BLOOD PRESSURE
- ☐ HEART TROUBLE
- ☐ STROKE
- ☐ CANCER
- ☐ SCOLIOSIS
- ☐ AUTOIMMUNE ISSUES
- ☐ THYROID DISORDER
- ☐ INSOMNIA/SLEEP ISSUES
- ☐ DEPRESSION
- ☐ GOUT
- ☐ DIZZINESS/VERTIGO
- ☐ SINUS/ALLERGY PROBLEMS
- ☐ UNEXPLAINED FEVER
- ☐ FATIGUE (TIRED)
- ☐ LOSS OF APPETITE
- ☐ UNEXPLAINED WEIGHT CHANGE
- ☐ NUMBNESS/TINGLING
- ☐ MUSCLE WEAKNESS
- ☐ FAINTING
- ☐ EPILEPSY/SEIZURES
- ☐ HEADACHES
- ☐ ASTHMA
- ☐ ANXIETY
- ☐ CONCUSSION
- ☐ DIGESTIVE PROBLEMS
- ☐ BOWEL/BLADDER CHANGES
- ☐ CHRONIC VIRAL INFECTION



Indicate your areas of pain with an **X** on the figures

*If X-rays are required there will be an **additional fee**.*
Please talk to staff if you have questions of costs. Initial here _____

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PATIENT CONSENT, PRIVACY NOTICE, AND FINANCIAL AGREEMENT RIVER RUN CHIROPRACTIC, INC.

I. PATIENT'S INFORMED CONSENT TO TREATMENT

Chiropractic treatment and physical therapy may involve many different treatments and therapies, including chiropractic adjustments, and other chiropractic procedures including manipulations, manual therapy, necessary diagnostic procedures, and physical therapy. I understand that all practices in medicine and healthcare, including chiropractic medicine and physical therapy always carry some risk to treatment. I further understand that in order to obtain the best treatment possible, it is important that I disclose all my medical conditions to my provider.

By signing below, I acknowledge that I consent to chiropractic, cranial sacral, functional medicine, muscle work, massage, and physical therapy treatment by Patrick Ryan River Run Chiropractic Inc., and understand that I have or will be informed about the nature, risks, and possible complications and consequences of the treatment; that available alternative methods of treatment to the procedures have or will be recommended to me; that I have the right to have my questions answered and to refuse any proposed treatment.

I understand that at times Patrick Ryan River Run Chiropractic Inc. provides training to individuals who are not licensed by the State of California and who work as interns, associates, masseurs, nutritional counselors or in other capacities as trainees. I understand that these unlicensed individuals may be involved in my treatment at times. However, I understand that any spinal manipulation will only be performed by a licensed practitioner.

II. PRIVACY NOTICE

Patrick Ryan River Run Chiropractic Inc., respects its patient's right to confidential treatment of the patient's medical, personal, and financial information. All of your medical and personal information is protected by the Health Insurance Portability and Privacy Act (HIPPA) and its accompanying regulations, and we will not sell your information to anyone. We may use or disclose your information as permitted by you or as allowed by law under the HIPPA guidelines.

The HIPAA Privacy Rule at 45 CFR 164.510(b) specifically permits covered entities to share information that is directly relevant to the involvement of a spouse, family members, friends, or other persons identified by a patient, in the patient's care or payment for health care. If the patient is present, or is otherwise available prior to the disclosure, and has the capacity to make health care decisions, the covered entity may disclose this information with the family and these other persons if the patient agrees or, when given the opportunity, does not object. The covered entity may also share relevant information with the family and these other persons if it can reasonably infer, based on professional judgment, that the patient does not object. In addition, the Privacy Rule expressly permits a covered entity to use professional judgment and experience with common practice to make reasonable inferences about the patient's best interests in allowing another person to act on behalf of the patient to pick up a filled prescription, medical supplies, X-rays, or other similar forms of protected health information.

You may share my personal health information with:

Name _____ Relationship_____

Contact Phone _____ Today's Date _____

III. FINANCIAL AGREEMENT

I understand that I am personally responsible for all charges associated with my care and treatment at Patrick Ryan River Run Chiropractic Inc., and will pay all amounts due within 20 days. If applicable, Patrick Ryan River Run Chiropractic Inc. will bill my health or auto insurance company, but I am ultimately responsible for all charges, whether or not paid by an insurance company, including any co-pays, co-insurance, or other charges.

I hereby assign all insurance benefits to which I am entitled, including Medicare, med-pay, private insurance, and any other health plans to Patrick Ryan River Run Chiropractic Inc. This assignment remains in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I acknowledge that I am financially responsible for all I hereby authorize the assignee to release all medical information necessary to receive payment.

FINANCIAL POLICY

-For your convenience, we are able to store a credit card on file for any balances.
-We ask for payment at the time of visit. If full payment is not made, statements will be mailed for any remaining balance.
-Receipts will be e-mailed out/printed upon request only.
-Superbills will be provided upon request that you can submit to your insurance for reimbursement.
-We do not bill insurance except for personal injury (car accident) cases.

(Financial Policy Continued)
- We are non-participating Medicare providers, which means Medicare patients pay us at the time of the visit. We will bill Medicare for reimbursement at the rates Medicare determines.
-Please let us know if you need to make payment arrangements if the cost of the care received creates a financial burden for you.
-Any sums not paid when due shall accrue interest at the applicable legal rate. Delinquent accounts will be referred to a collections agency.
-In any collections action or lawsuit brought by Patrick Ryan River Run Chiropractic Inc. to collect any past-due sums due on a Patient's account, or any other suit arising out of this Agreement, the prevailing party shall be entitled to have reasonable attorneys' fees and costs paid by the patient.

PATIENT SIGNATURE

By signing below, I acknowledge receiving, reading, and agreeing to Patrick Ryan River Run Chiropractic Inc.'s Policies and agree to the Consent to Treatment, Privacy Practices and Financial Agreement. To the extent that I am signing this document on behalf of another (e.g. as parent, guardian, or conservator), I represent and warrant that I have the authority to do so.

Patient's Name: _____ Signature: _____

Date: _____ Guardian (if patient is under 18 years of age) _____

APPOINTMENT CANCELLATION POLICY

24 HOUR CANCELLATION NOTICE REQUIRED

A 24 hour cancellation notice is required for any scheduled appointment at Patrick Ryan River Run Chiropractic Inc., including gift certificate sessions. We do this so that we can best accommodate all patients.

Rescheduled appointments within the 24 hour period before the scheduled appointment will be charged half the price of the visit.

Missed or no-show appointments (you simply do not show up for your appointment) you are responsible for paying the full cost of the appointment.

Emergency cancellations are determined at the discretion of the staff and doctor.

Email and text reminders can be set up for your account as a courtesy, but we cannot guarantee the accuracy of delivery. You are ultimately responsible for keeping track of scheduled appointments.

Patient Name: _____ Date: _____

Patient Signature: _____

CONSENT TO TREAT A MINOR (FOR PATIENTS UNDER 18 YEARS OF AGE)

I, _____, parent/legal guardian of _____(print minor First name, Last name) do hereby consent to any medical care determined necessary by the treating Practitioner at Patrick Ryan River Run Chiropractic Inc. Patrick Ryan River Run Chiropractic Inc. agrees to release all medical records of the child when requested by parent/guardian. All treating Practitioners also agree to discuss the care and progress of said child with parent/guardian. This authorization is effective from:

Parent or Legal Guardian Signature: _____ Date _____

Parent/ Guardian Name (print)_____ Witness Signature:_____