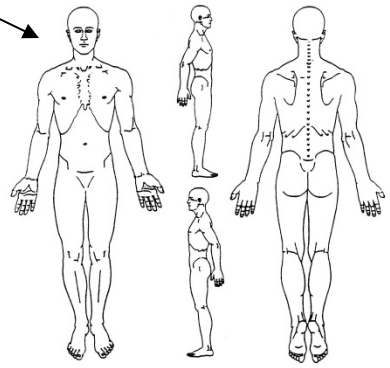
Initial Health Status

Patient Name:_____ Date Of Birth: _____ Sex: Male/Female
E-Mail Address:_____ SSN:_____-_____-_____
Address: _____ City: _____ State: _____ Zip:_____
Home Phone: _____ Cell Phone: _____ Patient Primary Language: _____
Occupation:_____ Employer: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip:_____
Insurance Company: _____ Subscriber Name: _____
ID Number: _____ Group Number: _____ Spouse Name:_____
Spouse Employer: _____ City: _____ State: _____ Zip:_____
Primary Care Physician Name: _____ Phone Number: _____

Mark an X on the picture where you have pain or other symptoms



Describe your current problem and how it began:
____Headache____ Neck Pain____ Mid-Back Pain____ Low Back Pain
____Other: _____
Is this? ___ Work Related ___ Auto Related ___ Sports Related ___ N/A
Date Problem Began: _____ How Problem Began: _____
_____
Current Complaint: (How your feel today):
|_____|
0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain
How often are your symptoms present?
Occasional: ____ 0-25% _____ 26-50% _____ 51-75% _____ 76-100% Constant
In the past week, how much has your pain interfered with your daily activities (ex: work, social activities, chores)?
|_____|
0 1 2 3 4 5 6 7 8 9 10
No Interference Unable to carry on any activities
In general, would you say your overall health right now is:
____ Excellent _____ Very Good _____ Good _____ Fair _____ Poor
Have you had spinal X-Rays, MRI, CT Scan for your area(s) of complaint? _____ Yes _____ No
Date(s) Taken: _____ What areas were taken? _____
Please check all of the following that apply to you:

____ Alcohol/Drug Dependence
____ Recent Fever
____ Diabetes
____ High Blood Pressure
____ Stroke, Date: _____
____Corticosteroid Use (Cortisone, Prednisone, etc.) Use
____ Taking Birth Control Pills
____ Dizziness/Fainting
____ Numbness in Groin/Buttocks
____ Cancer/Tumor (Explain)_____
_____
____ Osteoporosis
____ Epilepsy/Seizures
____ Other Health Problems (Explain)_____

____ Prostate Problems
____ Menstrual Problems
____ Currently Pregnant, # Weeks _____
____ Urinary Problems
____ Abnormal Wight Gain/Loss
____ Marked Morning Pain/Stiffness
____ Pain Unrelieved by Position or Rest
____ Pain at Night
____ Visual Disturbances
____ Surgeries _____
_____
____ Tobacco Use – Type: _____
Frequency _____
____ Medications: _____

Family History

____ Cancer ____ Diabetes _____ High Blood Pressure _____ Heart Problems/Stroke ____ Rheumatoid Arthritis

I certify to the bet of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: _____ Date: _____

McPeak Family Chiropractic

Gregory M. McPeak, D.C., ACRB Level 1

707 Huntingdon Pike
Rockledge, PA 19046

Are You At Risk For COVID-19

Have you recently traveled to a country with Level 3 Travel Health Notice? (*see below for list of countries)*

☐ YES ☐ NO

Have you been in contact with someone who has traveled to a country a Level 3 Travel Health Notice and is now sick?

☐ YES ☐ NO

Have you come into close contact (within 6 feet) with someone who has a laboratory confirmed COVID_19 diagnosis in the past 14 days?

☐ YES ☐ NO

Do you have a fever (greater than 100.4 F or 38.0 C) OR symptoms of lower respiratory illness such as cough, shortness of breath, difficulty breathing or sore throat?

☐ YES ☐ NO

Are you a first responder, healthcare worker, or employee or attendee of a child or adult care facility? *(Please circle or underline which one)*

☐ YES ☐ NO

Have you been told by a public health official that you many have been exposed to COVID-19?

☐ YES ☐ NO

Patient Name: _____ Date _____

Patients Signature: _____

Countries with a Level 3 Travel; Health Notice, updated by the CDC (as of 3/23/20)
-Australia - Brazil -Canada -China -Europe (Schengen Area):Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, Switzerland, Monaco, San Marino, Vatican City -Iran -Ireland -Israel - Japan -Malaysia -South Korea -United Kingdom: England, Scotland, Wales and Northern Ireland

PATIENT RIGHTS

McPeak Family Chiropractic respects the unique differences of our patients, and will ensure that health care ethics are maintained for all patients. The following rights will be exercised on our patient's behalf:

- The patient has the right to considerate and respectful care
- The patient has the right to, and is encouraged, to obtain from the doctor relevant, current, and understandable information concerning diagnosis, treatment, and prognosis
- The patient has the right to know the identity of the doctor, staff, and all involved in patient care
- The patient has the right to make decisions about the plan of care prior to and during the course of treatment, and to refuse a recommended treatment plan of care to the extent permitted by law, and to be informed of the consequences of this action
- The patient has the right to every consideration of privacy
- The patient has the right to expect that all communications and records pertaining to their care will be treated as confidential, except in cases where reporting is permitted or required by law
- The patient has the right to expect reasonable continuity of care when appropriate and to be informed by the doctor of available ad realistic patient care options

Patient Initials: _____

CONSENT TO TREATMENT OF A MINOR CHILD (under the age of 18)

I authorize spinal decompression, cold laser, chiropractic and or physical therapy care as deemed necessary to my (relationship to child)_____

Patient Initials: _____

FEMALE PATIENTS (ONLY)

I certify, to the best of my knowledge, that I am NOT pregnant. Beginning date of last menstrual period _____

Patient Initials: _____

PAYMENT, INSURANCE, MEDICAL RECORDS, AND USE OF NAME (for treatment if you accept care)

- I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.
- I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.
- I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, fees for products or professional services I rendered will be immediately due and payable.

Patient Initials: _____

AGREE TO XRAY ASSIGNMENT AGREEMENT

In the event that I receive payment for these services, I agree to promptly remit payment to the Radiologist or radiology service.

I assign my insurance benefits and rights to payment to the Radiologist to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company, attorney, and/or any third party payer. I authorize my reading physician insurance company, attorney, and/or third-party payer to provide the radiologist or their agents with any information concerning my claim, their services, and/or payment for the services provided.

Patient Initials: _____

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CONSENT TO CHIROPRACTIC AND/OR PHYSICAL THERAPY SERVICES

I hereby request and consent to comprehensive examinations (chiropractic and/or physical therapy, orthopedic and/or neurological), Chiropractic adjustments/treatments (and any other procedures including various modes of physiotherapy modalities), physical therapy intervention (including soft tissue mobilization, therapeutic exercises, stretching, posture and ergonomic training, and home exercise program, nutritional counseling/advice, and diagnostic x-rays) by McPeak Family Chiropractic and its staff, who now or in the future reside in this office. I have had an opportunity to discuss with McPeak Family Chiropractic's staff, the nature and purpose of the treatment indicated. I understand the results are not guaranteed and am informed that in the practice of medicine, in the practice of chiropractic, and in the practice of physical therapy, there are some risks to treatment, including but not limited to: fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor(s) to be able to anticipate and explain all risks and complications, and wish to rely on the doctor(s) to exercise judgement during the course of any procedure which the doctor(s) feels at the time is in my best interest. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by McPeak Family Chiropractic and/or employed staff.

Patient Initials: _____

NO SHOW/CANCELLATION POLICY

McPeak Family Chiropractic has the right to charge a fee of $50.00 for any cancelations done without at least 24 hours' notice of your scheduled appointment. Payment will be due upon next visit. If patient shows up for appointment more than 15 minutes late, we may reschedule or full treatment may not be rendered.

Patient Initials: _____

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.

PRINTED: _____ SIGNED: _____ DATE: _____

PARENT/GUARDIAN (If applicable) : _____ STAFF MEMBER: _____

McPeak Family Chiropractic

Gregory M. McPeak, D.C., ACRB Level 1

707 Huntingdon Pike
Rockledge, PA 19046
Phone # (215)379.0640
Fax # (215)379.0561
M/W/F: 9am-12:30 & 2:30-7pm
Tuesday: 2-7pm

Name: _____
Cell Phone Number: _____
E-Mail Address: _____
Primary Care Physician: _____
Please Provide Location (City/State)

Is your health insurance the same since your last appointment?

☐ Yes ☐ No

If not, please provide new insurance card and carrier.

Has your residence/address changed in the past 6 months?

☐ Yes ☐ No

If yes, please provide new address: _____
_____

Be advised of our new COVID-19 office policy, 24-hour notice is required for all cancellations or a $40 fee will be charged. _____
Initial

_____ _____ _____
Print Name Signature Date

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PRIVACY PATIENT CONSENT FORM

Our Summary Notice of Privacy provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do. We shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations, you have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. McPeak Family Chiropractic provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- McPeak Family Chiropractic has a summary notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- McPeak Family Chiropractic reserves the right to change the notice of Privacy Policies.
- The patient has the right to restrict the use of their information but McPeak Family Chiropractic does not have to agree to those restrictions. Any restrictions will be reviewed by our HIPAA Compliance Committee and the patient will be notified of their final decision.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease. Requests will be forwarded to the SFEA HIPAA Compliance Committee.
- McPeak Family Chiropractic may condition treatment upon the execution of the Consent.

This Consent was signed by:_____
(Patient or Representative)

Print Patient Name: _____

Relationship to Patient (if other than patient)_____

Date: _____

In front of _____
(McPeak Family Chiropractic)

_____ Patient refused to sign. Reason:_____