Welcome to Our Office

Patient Intake

This Patient Intake will serve as the patient paperwork and Legal Release for all providers within our Practice Management Group: Beyond Wellness LLC, Loudoun Family Chiropractic LLC, Dee Chiropractic PLLC, Natural Health Therapies LLC, Araya Holistic Pain Management LLC, Elite Performance Chiropractic and Wellness LLC and Core Health Chiropractic.

Patient Information

Name: _____
(Last) *(First)* *(M.I.)* *(Prefer to be called)*

Date of Birth: ____/____/_____ Age: _____ Sex: ☐ Male ☐ Female

Marital Status: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Contact Numbers

Home: _____ Cell: _____ Work: _____
(Only if we may call you at this number)

Email: _____

Employer: _____Occupation: _____

Emergency Contact

Name: _____ Phone Number: _____ Relationship: _____

How did you hear about us?

- ☐ Doctor Referral: _____
- ☐ Physical Therapist Referral: _____
- ☐ Family/Friend/Co-worker: _____
- ☐ Coach/Personal Trainer: _____
- ☐ Other: _____
- ☐ Health Insurance Company
- ☐ Facebook
- ☐ Google
- ☐ Yelp
- ☐ ZocDoc

Legal Releases

Read and initial each section. Sign and date at the bottom.

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_____ Consent to Care

(Initial) Consultation and examination are conducted for diagnostic and informational purposes. A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities, or pathologies, may render the patient susceptible for injury. The doctor will not provide specific healthcare if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make known to the doctor any latent pathological defects, illnesses, or deformities which would otherwise not come to the doctor's attention. My case may not be accepted for treatment at this clinic. If the doctor believes that I may respond to their care, additional services may be recommended, and I will be advised of applicable cost. **If the patient is a minor, I, as the parent or legal guardian, give permission for my child to receive chiropractic care.**

_____ Privacy Notice

(Initial) The Health Insurance Portability Accountability Act of 1996 (HIPAA) requires that we receive your permission before we use the personal information in your medical records for any reason. A signed consent form permits us to use your personal health information within our Practice Management Group for the purposes of treatment, receiving payment, and health care operations of our practices. It is the policy of our practices to release only the minimum necessary information to any source not directly linked to hands on care and treatment of patients in our offices as outlined in HIPAA. This includes third party payers, insurance companies, etc. If protected health information must be released, the patient or outside entity must provide us with a medical records release form signed by the patient. Where required by law we will only release the minimum information necessary to law enforcement or public health agency. You, as the patient, have the right to see your medical record during normal office hours. You also have the right to revoke in writing this consent at any time. A copy of our privacy policy is available upon request.

_____ Financial Policy/Cancellation and Rescheduling Fee

(Initial) Your insurance contract is between you, your employer, and the insurance company, please contact your insurance company for any coverage questions or issues. Not all services are covered by all contracts. We will file a claim for you with your **primary** insurance company only on your behalf. Any copays, coinsurance, deductible payments, remaining balances and fees are your responsibility. If you are not using insurance, you will be charged our cash rate. Payment is due at time of service, unless other arrangements, based on financial cause, have been made through our billing department. A $30 fee will be charged for returned checks. We require 24 hours' notice for all appointment cancellations and rescheduling. A $50 fee may be charged if notice is less than 24 hours.

I authorize release of any information necessary to my insurance company to determine benefits for services rendered. I understand that I am responsible for any balance in my account regardless of my insurance status. I understand I am responsible for providing up to date insurance information. I understand the cancellation/rescheduling policy and that I am responsible for any fees that have been charged.

Signature: _____ Date: _____

(Patient, Parent, or Legal Guardian)

Printed Name: _____

Patient Case History

1: Reason for Visit

Type of Injury: ☐ Job-Related ☐ Auto-Accident ☐ Exercising ☐ Other/Unknown

What is your primary concern?	
When did your concern begin?	
What were you doing when you first noticed your concern?	
Any prior similar concerns? Explain	
When did they occur?	

On the scale below, circle the **severity** of your concern. *(Right now)*

None		Minimal		Mild		Moderate			Severe	
0	1	2	3	4	5	6	7	8	9	10

On the scale below, circle the **severity** of your concern. *(At its worst)*

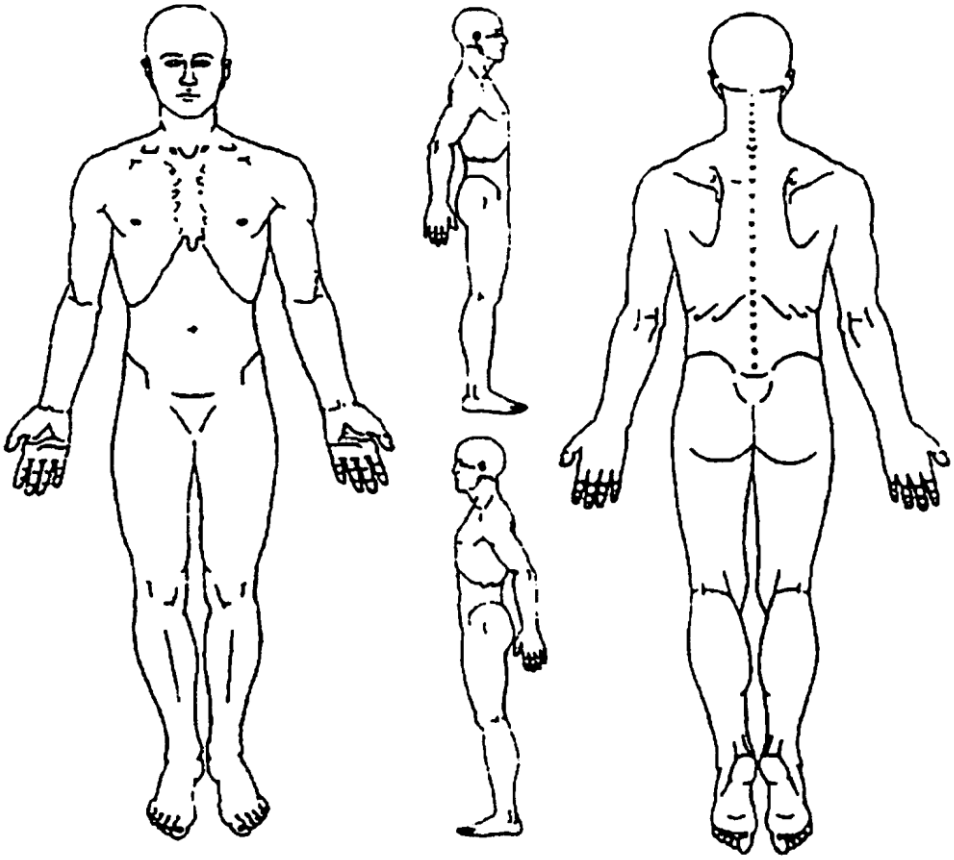
None		Minimal		Mild		Moderate			Severe	
0	1	2	3	4	5	6	7	8	9	10

How **often** are you experiencing your symptoms on an average day?

Occasional			Intermittent			Frequent			Constant	
0	1	2	3	4	5	6	7	8	9	10

Using the legend, mark where you are experiencing all symptoms.

Achy/Dull **B**urning **C**ramping/Stiff **N**umbness/Pins/Tingle **S**tabbing



Do you have pain or difficulty performing the following activities? *Check all that apply.*

- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Running
- ☐ Climbing Stairs
- ☐ Lying Down/Sleeping

- ☐ Working
- ☐ Driving

- ☐ Lifting
- ☐ Bending
- ☐ Twisting
- ☐ Exercising

2. Other Health Concerns

Do you have any other concerns?	1.Where?	
	Describe.	
	2.Where?	
	Describe.	
What services are you interested in? (Mark all that apply)	☐ Acupuncture ☐ Nutrition Counseling/Weight Loss ☐ Yoga ☐ Meditation	☐ Massage ☐ Reiki ☐ Patient Education Classes ☐ Balance and Coordination Training

3. Conditions

Mark the following conditions as they currently pertain or have pertained to you in the past

☐ Acid Reflux ☐ Alcoholism ☐ Anemia ☐ Arthritis ☐ Anxiety/Depression ☐ Asthma ☐ Bruise Easily ☐ Numbness/Tingling ☐ Concussion ☐ Other (Please specify) _____	☐ Diabetes ☐ Disc Degeneration ☐ Disc Herniation ☐ Fatigue ☐ Frequently Sick ☐ Gall Bladder Dysfunction ☐ Heart Disease ☐ Hepatitis/Liver condition ☐ High Blood pressure	☐ High Cholesterol/LDL ☐ Hot Flashes ☐ Hypoglycemic ☐ Irritable Bowel Syndrome ☐ Kidney Disorders ☐ Lupus ☐ Lyme's Disease ☐ Measles/Mumps ☐ Mental Illness	☐ Migraines ☐ Multiple Sclerosis ☐ Osteoporosis/Osteopenia ☐ Poor Digestion ☐ Restless Leg Syndrome ☐ STD's/HIV ☐ Stroke ☐ Thyroid Dysfunction

4. Medical History (*Use the back of this page if needed*)

Please list **all** surgeries and dates of occurrence.	
Please list **all** medications you are currently taking (prescription and over-the-counter).	
Please list **all** vitamins and nutritional supplements that you are currently taking.	
Please list **all** allergies.	
Please list **all** hospitalizations and auto accidents and the dates of occurrence.	

5. Social History and Life Choices

I exercise…	☐ Daily	☐ 2-3x's/week	☐ 1x/week	☐ Infrequently	☐ Never
Average time spent exercising…	☐ >1 hour	☐ 1 hour	☐ 30 min	☐ <30 min	☐ n/a
My stress level is…	☐ Severe	☐ High	☐ Moderate	☐ Mild	☐ None
I smoke…	☐ No	☐ Yes	How much?		
I consume alcohol…	☐ >1 Daily	☐ Daily	☐ Weekly	☐ Infrequently	☐ Never
I consume caffeine…	☐ >1 Daily	☐ Daily	☐ Weekly	☐ Infrequently	☐ Never
I consider my general health to be…	☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor

6. Family Health History

Please note any family members with the following conditions:

Diabetes		Osteoporosis	
Heart Disease/Stroke		Arthritis	
Cancer		Thyroid Disease	
Autoimmune Disease		Other	

Office use only

Payment Authorization Agreement

This Payment Authorization form will serve as the patient authorization and agreement for all providers within our Practice Management Group: Beyond Wellness LLC, Loudoun Family Chiropractic LLC, Dee Chiropractic PLLC, Natural Health Therapies LLC, Araya Holistic Pain Management LLC, Elite Performance Chiropractic and Wellness LLC and Core Health Chiropractic.

Patient(s) Name_____

Choose one of the following options:

❑ Option 1: Auto-Debit Virtual Terminal Authorization (your credit/debit card will be charged the next business day after your appointment)

I, [print name] _____, hereby authorize Beyond Wellness Practice Management Group LLC (BWPMG) and/or its contracted providers **to *initiate charges and corrections to previous charges to the card indicated below*.** These charges will reflect payment for performed services, supplements, health products, telephone consultations, missed appointment and late cancellation fees. If the card I have provided below is lost, stolen, or expires it is my responsibility to contact BWPMG and provide an alternate form of payment. I acknowledge that email receipts for all services and products will be sent to the email address I have provided. Authorization for this service is to remain in effect until I provide a written request of its withdrawal. BWPMG only accepts Visa® and MasterCard®. **Information provided below should be written legibly in print.**

Card Type: ❑ VISA ❑ MASTERCARD
❑FSA/HSA when are funds usually deposited into account? _____

Name on Card: _____

CC/Debit Card Number: _____

Card Expiration Date: _____/_____

(Card holder, if different from patient, must sign and date)

Card Holders relationship to Patient: _____

Card Holders Signature: _____ Date: _____

❑ Option 2: Pay Online

I will pay online (www.mybwdoc.com) for my services and products within **48 hours** after my appointment. **(You will receive a patient statement the next business day after your appointment by email with your account # and instructions for paying online. Please check your spam folder for emails from** billing@mybwdoc.com **)**

❑ Option 3: Pay by Phone

I will pay by Phone for my services and products within **48 hours** after my appointment by calling (703) 723 - 9355, press "4". (**You will receive a patient statement the next business day after your appointment by email. Please check your spam folder for emails from** billing@mybwdoc.com **)**

Patient (or Parent of) Signature: _____ Date**:** _____