SHAKER WOMEN'S WELLNESS

Patient Intake Form

Personal Information

Full Name: _____ Date of Birth: _____ SS#:_____

Address: _____City: _____ State/Zip: _____

Phone: _____ Email: _____ Sex: M F Age: ___

Occupation: _____ Employer/School: _____

Spouse's Name: _____ Date of Birth: _____ SS#:_____

Spouse's Employer: _____ Who can we thank for referring you? _____

Emergency Contact:_____ Relationship: _____ Phone: _____

Insurance Information

Insurance Company: _____

ID #: _____

Group #: _____

Who is responsible for this account? _____

Relationship to Patient: _____

Is the patient covered by any additional insurance? Yes No

Insurance Company: _____

ID #: _____

Group #: _____

Who is responsible for this account? _____

Relationship to Patient: _____

Assignment and Release:

I certify that I, and/or my dependent(s) have insurance coverage with the above companie(s) and assign directly to Dr. Sedgwick and Shaker Women's Wellness all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The aboved-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian, or Personal Representative

_____

Signature of Patient, Parent, Guardian, or Personal Representative

_____

Date Relationship to Patient

Accident Information

Is condition due to an accident? ◯ Yes ◯ No Date:_____

What type of accident?

◯ Auto ◯ Work ◯ Home ◯ Other

To whom have you made a report of your accident?

_____

Attorney & Phone (if applicable):_____

Patient Information

Reason for Visit: _____

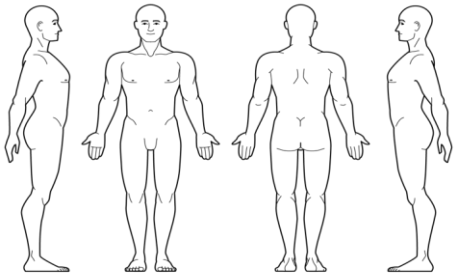
_____

When did your symptoms appear? _____

Is this condition getting progressively worse?

◯ Yes ◯ No ◯ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling:



Rate the severity of your pain on a scale from 1 (least) to 10 (severe pain): _____

Type of pain:

_____Sharp	_____Dull
_____Throbbing	_____ Numbness
_____Aching	_____Shooting
_____Burning	_____ Tingling
_____Cramps	_____Stiffness
_____Swelling	_____Other

How often do you have this pain? _____

Is it consistent or does it come and go? _____

Does it interfere with your:

◯ Work ◯ Sleep ◯ Daily Routine ◯ Recreation

Activities or movements that are painful to perform:

◯ Sitting ◯ Standing ◯ Walking ◯ Bending ◯ Lying Down

Exercise

◯ None ◯ Moderate ◯ Daily ◯ Heavy

Work Activity

◯ Sitting ◯ Standing ◯ Light Labor ◯ Heavy Labor

Habits

◯ Smoking	Packs/Day_____
◯ Alcohol	Drinks/Week_____
◯ Coffee/Caffeine Drinks	Cups/Day_____
◯ High Stress Level	Reason_____

Health History

Are you Pregnant? How far along?
◯ Yes ◯ No _____

What treatment have you already received for your condition?
◯ Medications ◯ Surgery ◯ Physical Therapy
◯ Chiropractic Services ◯ None ◯ Other:
_____

Name and Address of other doctor(s) who have treated you for this condition: _____
_____

Date of Last Exam:

Physical Exam: _____
Spinal Exam: _____
Dental X-ray: _____
Spinal X-ray: _____
Chest X-ray: _____
MRI/CT/Bone Scan: _____
Blood Test: _____
Urine Test: _____

Please indicate "X" to any of the following that you have/had:

_____AIDS/HIV	_____High Cholesterol
_____Alcoholism	_____Kidney Disease
_____Allergy Shots	_____Liver Disease
_____Anemia	_____Low Blood Pressure
_____Anorexia	_____Migraines
_____Appendicitis	_____ Miscarriage
_____Arthritis	_____Mononucleosis
_____Asthma	_____Multiple Sclerosis
_____Breast Lump(s)	_____Osteoporosis
_____Bulimia	_____ Pacemaker
_____Cancer	_____ Parkinson's Disease
_____COVID	_____Pinched Nerve
_____Diabetes	_____POTS
_____Endometriosis	_____ Prosthesis
_____Epilepsy	_____Psychiatric Care
_____Fractures	_____Rheumatoid Arthritis
_____Gout	_____Scoliosis
_____Headaches	_____Stroke
_____ Heart Disease(s)	_____Suicide Attempt
_____Hernia	_____Thyroid Problems
_____Herniated Disc	_____Tumors/Growths
_____High Blood Press.	_____ Vertigo

Other: _____

Injuries/Surgeries you have had: (Falls, Head injuries, Broken Bones, Dislocations, Surgeries)

Date	Description
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medications:

Name	For What	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Vitamins/Herbs/Minerals/Supplements:

Name	For What	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any allergies or sensitivities?

◯ Yes ◯ No

If yes, please explain: _____
_____

By signing below, you agree to the following.

I have completed this form to the best of my ability and knowledge and agree to inform my provider if any of the above information changes at any time.

Name: _____ Signature: _____ Date: _____

SHAKER WOMEN'S WELLNESS
Premier Chiropractic Care

INFORMED CONSENT TO CHIROPRACTIC CARE

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions prior to signing if anything is unclear.

The Chiropractic Adjustment:

The primary treatment that Dr. Sedgwick uses is spinal manipulative therapy. The doctor will use that procedure to treat you, the patient. The doctor may use her hands or an instrument upon your body as a way to correct the alignment of your joints. This may cause an audible "click" or "pop". You may feel a sense of movement. The goal of this treatment is to restore mobility to the area and relieve associated nerve pressure.

Risks:

As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation and therapy. These complications include, but are not limited to fractures, dislocations, stroke, muscle strain, cervical myelopathy, costovertebral strains, and disc injuries. Some patients feel soreness and stiffness following the first few days of treatment. The doctor will make every effort to minimalize any risks.

Fractures are rare and usually result from underlying weakness of the bone, which the doctor will check for during the history and examination. Stroke has been the subject of tremendous disagreement. The incidence of stroke is estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

Alternative Options:

Other treatment options available to you include: no treatment, self-administered over the counter analgesics and rest, and medical intervention such as prescription medications, hospitalizations, and surgery.

I have read and understand the above, and I have discussed my concerns with the doctor. Having been informed of the risks, I hereby give my consent to treatment.

Name (Printed): _____ Date: _____

Patient Name (if different from above): _____

Signature: _____

SHAKER WOMEN'S WELLNESS
Premier Chiropractic Care

Patient Health Information Consent Form

We want you to know how your **Patient Health Information (PHI)** is going to be used by **Shaker Women's Wellness** 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 with Dr. Sedgwick 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 Dr. Sedgwick 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. Dr. Sedgwick 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 at their home/office.

4. The patient may provide a written request to revoke consent at any time during care. This would not effect 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. We have taken all precautions that are known 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, Dr. Sedgwick has the right to refuse to give care.

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

Name of Patient: _____ Date: _____

Signature: _____

SHAKER WOMEN'S WELLNESS
Premier Chiropractic Care

FINANCIAL POLICY

The following is an explanation of the policy implemented by Shaker Women's Wellness. We believe that a clear definition of our financial policy will allow both the doctor and you to concentrate on re-establishing, retaining and maintaining your health.

Payments

- We will be happy to verify your benefits and health coverage with your insurance company; however, that is not a guarantee of payment. It is your responsibility to understand your health insurance policies. We are not responsible for knowing when you meet your deductible or out of pocket.
- ALL CO-PAYS and CO-INSURANCE are due at the time of service.
- If you do not have insurance or choose not to file with your insurance company, all payments are expected at the time of service.
- There will be a $10 charge added to all balances every 30 days overdue. In addition, there will be a 1.5% finance charge added to all balances after 60 days.
- There will be a $25.00 charge on all returned checks.

Insurance Coverage

- Our fees are considered usual, customary and reasonable by most companies, and therefore covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing not relationship to the standard of care in this area.
- If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance.

Assignment and Release

I, _____, agree to assign Dr. Angela Sedgwick of Shaker Women's Wellness, all insurance benefits, if any, otherwise payable to me for services rendered. I also authorize the use of my signature on all insurance submissions.

____ I agree to pay my deductible/copay/co-insurance at the time of service

____ Please place a credit card in my file for this and future payments. (Credit card charge will occur day of visit)

Credit Card No: _____ Exp:____/_____

CVV: _____ Zip Code for Card: _____

I have read and understand the financial policies of Shaker Women's Wellness, and I will honor them. If a credit card is placed on file, it will be secured through Square Payment Processing.

Patient Signature: _____ Date: _____