MURPHY FAMILY CHIROPRACTIC

INTAKE FORM

In order to keep our records up-to-date and to best serve you, please complete the following. Please complete all information and print legibly;

Today's Date: _____

Name: _____ How would you like to be addressed? _____

Address: _____

City:_____ State: ____ Zip: _____ Date of Birth: _____

Cell Nbr: (_____) _____ Gender (circle): M F Age: _____

Hme Nbr: (_____) _____ Marital status (circle): S M W D P

Wrk Nbr: (_____) _____ Email Addr: _____

Employer: _____ Your Occupation: _____

Your Emergency Contact: _____ Contact #: (_____) _____

Who is ultimately responsible for this account? _____

Address: _____ City:_____ State: ____ Zip: _____

Contact Nbr: (_____) _____

Do You Drink Alcohol (circle)? Y N How Much? _____

Do You Smoke (circle)? Y N How Much? _____

Do You Exercise (circle)? Y N How Often? _____ Type?_____

Allergies? (please specify): _____

Have You Ever Suffered From Or Been Diagnosed As Having Any Of The Following Since Your Last Update/Intake (circle):

Y N	A Congenital Disease*	Y N	Head Injuries/ Concussions/ Problems*
Y N	Alcoholism/Drug Addiction*	Y N	High/Low Blood Pressure
Y N	Broken/Fractured Bones *	Y N	HIV / AIDS*
Y N	Cancer*	Y N	Implants Type_____
Y N	Coughing Blood	Y N	Pacemaker / ICD / Shunt *
Y N	Depression	Y N	Osteoarthritis*
Y N	Diabetes*	Y N	Rheumatoid Arthritis*
Y N	Disc Bulge/Hernia*	Y N	Vascular Problems*
Y N	Eating Disorder	Y N	Skin Disorders*
Y N	Epilepsy/Seizures/Convulsions*	Y N	Strokes
Y N	Excessive Bleeding	Y N	Tumors
Y N	Gastrointestinal Problems*	Y N	Other Musculoskeletal Problems*
Y N	Arm / Leg Problems*	Y N	Neurological Problems/ Headaches*

•Explanation:_____

Patient: _____

List any recent surgeries, procedures, diagnoses or complaints not identified on the first page: _____

_____

Family History - has anyone in your family (back to Grandparents) recently suffered from or been newly diagnosed as having any of the conditions listed at the bottom of page 1? (List who & what condition)

_____

Date of Your Last Physical Exam? _____

When was the last time you were involved in a motor vehicle accident or fall? _____

Medication/Vitamin List (please list all within the last year):

Name of Medication or Vitamin	Date Started	Date Stopped	Dosage	Who Prescribed? D=Doctor, S=Self

(use back of sheet if necessary and check the box to let us know there's more information on the back) ☐

What is your main (primary) complaint? _____

_____

How long have you been experiencing your main complaint?_____

On the scale below, please circle the *severity* of your main complaint – at it's worst:

mild moderate severe

1	2	3	4	5	6	7	8	9	10

On the scale below, please circle the *percentage of time* you experience your main complaint:

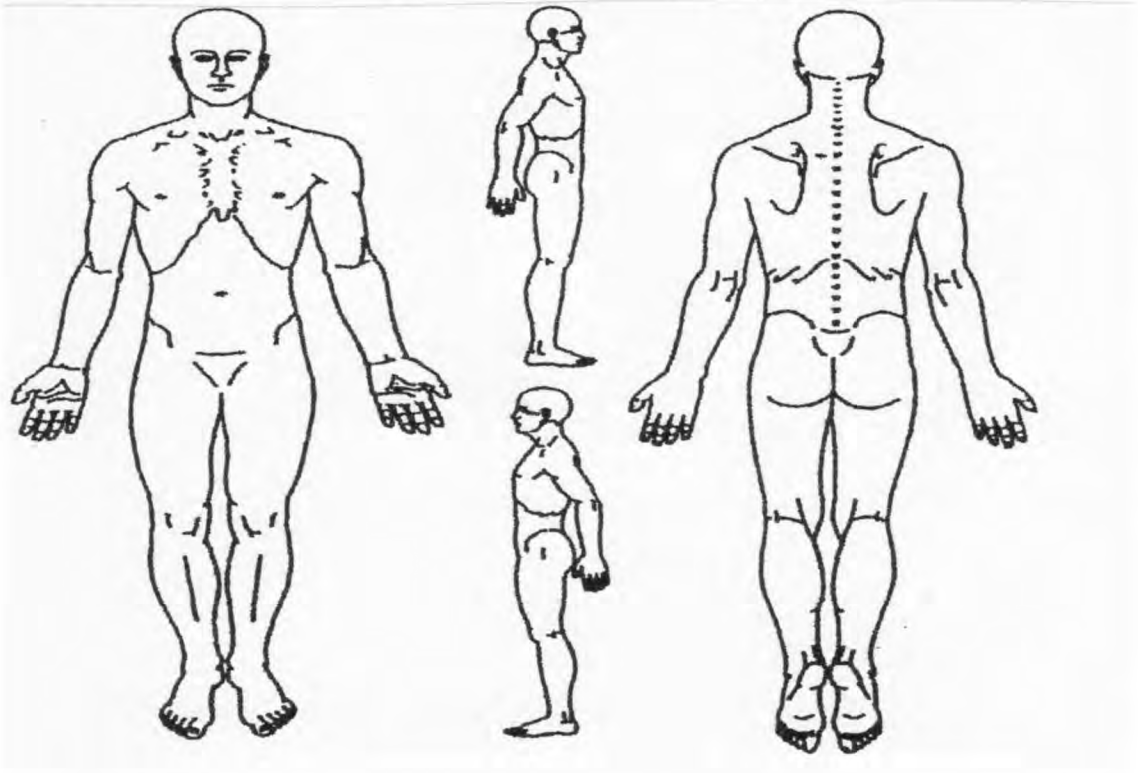
occasional intermittent frequent constant

0	10	20	30	40	50	60	70	80	90	100	%

Patient: _____

On the diagram below, please show where you are experiencing **all** of your present complaints. Use:

A = ache	C=cramping	R=throbbing pain	T=tingling
B=burning pain	D=dull pain	N=numbness	ST=stiffness



When do you notice your main complaint the most (circle)? AM PM

What makes it feel better? _____

What makes it feel worse? _____

Have you ever had this problem in the past (circle)? Y N

How many episodes have you had? _____

I have:
___ been hospitalized
___ been treated by another chiropractor
___ been treated by another specialty provider
___ never received care for this problem

Have you lost time from work because of it (circle)? Y N

Dates: _____

If applicable:

Are you pregnant (circle)? Y N

What was the first day of your last menstrual cycle? _____

Number of pregnancies? _____

Number of miscarriages? _____

Do you have pain and/or difficulty performing any of the following activities (check all that apply):

Personal care: ___
Lifting: ___
Reading: ___
Concentrating: ___
Working: ___
Driving: ___
Sleeping: ___
Recreation: ___
Walking: ___
Sitting: ___
Standing: ___
Social Life: ___
Sex: ___

_____ _____

Patient Signature Date

Patient: _____

AUTHORIZATION FOR CHIROPRACTIC TREATMENT

I, the undersigned, a patient in this office, hereby authorize Murphy Family Chiropractic/Dr. Timothy D. Murphy (and whomever he may designate as his alternate) to administer such treatment as is necessary, and to perform the needed therapy and procedures that are considered therapeutically necessary on the basis of finding during the course of my treatment.

I hereby certify that I have red the fully understand this Authorization For Chiropractic Treatment. I further certify that the reasons why treatment is considered necessary, its advantages and possible complications, if any, as well as possible alternative modes of Treatment have been explained to me by Dr. Murphy (or his alternate). I also certify that no guarantee or assurance has been made to me as to the results that me be obtained.

By my signature below, I hereby state that to the best of my knowledge I am NOT pregnant at this time. I consent to the performance of the suggested radiographic studies based on this consideration, and am acknowledging a willingness for these tests to be considered.

_____	_____	_____
Printed Name of Patient	Signature of Patient	Date

LETTER OF NO ACCIDENT OR INJURY

I _____ hereby state with my signature that I was NOT involved in any auto accident, slip and fall or work injury. My request for treatment is therefore in no way associated with any 3rd party and no other party is responsible or liable for the cost of my treatment.

_____	_____	_____
Printed Name of Patient	Signature of Patient	Date

Patient: _____

HEALTH CARE AUTHORIZATION

I, _____, born _____ authorize
printed patient name date of birth (mm/dd/yyyy)

Murphy Family Chiropractic/Timothy D. Murphy, D.C. and his staff to use or disclose protected health information in accordance with the following;

_____ patient initials

I give permission to Murphy Family Chiropractic/Timothy D. Murphy, D.C. and his staff to use my address, telephone number(s), email address and clinical records to contact me with appointment reminders, missed appointments notifications, holiday related cards, information about treatment alternatives and other health related information.

_____ patient initials

If Murphy Family Chiropractic/Timothy D. Murphy D.C. and his staff contact me by telephone I give them permission to leave a message on my answering machine/voice mail or to text me via my cell phone.

By initialing each directive above and by signing this form, you are authorizing Murphy Family Chiropractic/Timothy D. Murphy, D.C. and his staff to use and disclose your protected health information in accordance with Federal HIPAA Regulations for claims reimbursement and in accordance with the directives listed above.

You have the right to revoke this authorization at any time. Your revocation must be in writing and is not effective to the extent that Timothy D. Murphy D.C. and his staff have provided services or taken action in reliance on your authorization. Your written revocation is not effective until received by the Privacy Officer for Murphy Family Chiropractic/Timothy D. Murphy D.C. and must contain the following information;

- Your full name, social security number and date of birth
- A clear statement of your intent to revoke this Authorization
- The effective date of your request
- Your signature.

Your written revocation may be mailed or hand-delivered to Deborah Murphy, the Privacy Officer for Timothy D. Murphy, D.C. at; MURPHY FAMILY CHIROPRACTIC
20971 E. Smoky Hill Rd. Ste #203
Centennial, CO 80015

This Authorization is requested by Timothy D. Murphy, D.C. and his staff for their own use/disclose of Protected Health Information. You have the right to refuse to sign this Authorization and doing so will not inhibit your right to receive treatment from Timothy D. Murphy, D.C. and his staff. You have the right to inspect and copy any Protected Health Information that may be used or disclosed and you have the right to receive a signed copy of this authorization upon request.

_____ _____ _____
Printed Patient Name Signature of Patient/Guardian Date

Patient: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

NOTICE TO CLIENT

This form will be retained in your medical record.

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your protected health information (PHI). Please sign this form to acknowledge receipt of the Notice.

Your Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Murphy Family Chiropractic. I understand that the Notice describes the uses and disclosures of my protected health information by Murphy Family Chiropractic and informs me of my rights with respect to my protected health information.

_____ _____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____ _____

Employee Name *Today's Date*

Patient: _____

APPOINTMENT AND FINANCIAL POLICIES

Thank-you for choosing my practice for your chiropractic needs. My goal is to provide the *highest quality of patient care* possible while keeping payment for all services rendered both easy and economical. Out of respect for our patient's busy schedules, the office reserves a specific time for your chiropractic appointment and makes every attempt to run on time. In return, we ask that you;

- Please call ahead if you are unable to keep your appointment. This permits the office to schedule another patient in your vacated time slot. If you fail to call ahead and/or do not show up for your appointment, we reserve the right to charge a ***$50.00 missed appointment fee***. If your chiropractic care is paid for by a 3rd party you will be personally responsible for the missed appointment fee as we cannot bill missed appointments to a 3rd party.

- Please arrive on time for your appointment. If you are running late, the courtesy of a telephone call to let us know is appreciated. This allows Dr. Murphy to see other patients while we await your arrival and ensures that we reserve another time slot for you.

- Walk-ins are welcome however please understand that scheduled patients take priority. Calling ahead to let us know you're coming allows us to provide you with an estimated wait time.

We understand that emergencies occasionally arise that may prevent you from adhering to this appointment policy. Implementation of this policy is designed to help us better serve our patients and eliminate continued disrespectful behavior rather than 'punish' patients in the event of an emergency.

Our office strives to provide the highest quality of patient care possible while keeping payment for all services rendered both easy and economical. In return, we ask that;

- Payment is remitted at the time services are rendered, unless prior arrangements have been made (e.g. a monthly payment plan)

- Returned checks will be charged the bank's NSF fee (currently $35.00)

- Declined credit cards (not resolved within 5 business days) will be charged a $35.00 NSF fee.

- Cash, check or credit card (Mastercard or Visa) are all acceptable methods of payment.

My signature below denotes my understanding of and agreement with these Appointment and Financial Policies

Patient's Printed Name	Patient/Guardian's Signature	Date

Patient: _____

TIME OF SERVICE DISCOUNTS

The state of Colorado is one of many states that DOES allow chiropractors to discount their fee if payment for services is remitted in full at the time services are rendered.

The OIG (Office of Inspector General) advises;

- that chiropractic time of service discounts should not exceed 15%,
- that the discount must be directly tied to the "book keeping savings" that is allowed the Practice by not having to submit claims, complete follow up etc. and,
- that the time of service discount must be clearly defined within the practice's Financial Policies so as to eliminate confusion and misunderstanding.

Murphy Family Chiropractic offers our patients who wish to pay for their chiropractic care themselves, the following time a time of service discount:

Standard Chiropractic Fee for a 1-2 segment chiropractic adjustment = $55.00
Time of service fee for a 1-2 segment chiropractic adjustment = $45.00
(Note: fees are subject to change at any time with or without prior notice)

To be eligible for a Time of Service discount, the OIG (Office of Inspector General) requires that;
"payment for chiropractic services be paid at the time of the service and no claims submission, billing or waiting for payment applies.
This means, for eligible patients, if they say "bill me" or "I'll bring a check in next week", they are ***not*** eligible for the time of service discount".

Murphy Family Chiropractic adheres to the aforementioned OIG regulations and therefore requires payment in full AT THE TIME CHIROPRACTIC SERVICES ARE RENDERED (unless you have *prepaid* for your care via a monthly payment plan).

My signature below denotes my understanding of and agreement with this Time Of Service Discount Policy.

_____	_____	_____
Patient's Printed Name	Patient/Guardian's Signature	Date

Source: ChiroCode Institute Newsletter dated 12/30/15
"Time of Service Discounts" by Brandy Brimhall CPC CMCO CPCO CCCPC CPMA