



# Patient Intake Form

## General Information: (Please Print Clearly)

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F  
(Last) (First) (Middle Initial)

Address: \_\_\_\_\_

Phone- Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_  
(Please Indicate Preferred Method of Contact)

Email: \_\_\_\_\_ Referred by: \_\_\_\_\_  
(Your email will NOT be shared with any 3<sup>rd</sup> parties and is only used for general office communication)

Emergency Contact & Phone #: \_\_\_\_\_ , \_\_\_\_\_

Drivers Lic.#: \_\_\_\_\_ SSN: \_\_\_\_\_ Marital Status: S M D W DP

Name of Spouse/Parent \_\_\_\_\_ Spouse/Parent Contact # \_\_\_\_\_

Chief Complaint(s): \_\_\_\_\_

## Insurance & Payment Information:

Reason for this visit is a result of (please circle): **Auto Chronic Fall Sports Work Other**

Has your accident or Injury been reported: **Yes No** To Whom: \_\_\_\_\_

Party Responsible for Payment: **Insurance Self Work Comp Other:** \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Do you have Insurance? **Yes No**

\*Special consideration may be given if you qualify for a certain plan. Please indicate if you feel this may apply

to you: Athletic Organization: \_\_\_\_\_ Member since \_\_\_\_\_

Dance Organization: \_\_\_\_\_ Member since \_\_\_\_\_

\*\*I understand and agree that health and accident insurance are an arrangement between an insurance carrier and myself. I clearly understand and agree from my insurance carrier directly to this office with the understanding that all money credited to my account upon receipt. I clearly understand and agree that I am personally responsible for payments for all services rendered to me and charged to me. I understand that if I suspend or terminate my care and treatment all fees for professional services rendered to me will be immediately due and payable. In the event of my default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Current Complaints

Chief complaint(s): \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Date Symptoms Began: \_\_\_\_\_

How did your pain begin?  Immediately after a specific event  After multiple events  
 Gradually developed  No apparent reason

Are your pain or symptoms:  Improving  Worsening  Not changing

Are your pain or symptoms:  Constant (75-100% of time)  Frequent (51-75%)  
 Occasional (25-50%)  Intermittent (25% or less)

Have you ever had a similar problem before? **Yes** or **No** If so, When? \_\_\_\_\_

Does anything decrease your pain or symptoms? \_\_\_\_\_

What makes your pain worse? \_\_\_\_\_

Is this interfering with your (please circle) **Work Sleep Daily Routine Sports Recreation**  
Other? If so, please explain: \_\_\_\_\_

Have you been treated for any of these conditions in the past year? **Yes** or **No**  
If **YES**, please check:  Surgery  Injections  Physical Therapy  Supportive devices  
 Medications \_\_\_\_\_ Other \_\_\_\_\_

Did they help? **Yes** or **No**

Prior tests, results and dates: (X-ray, MRI, CT, ultrasound, lab, other): \_\_\_\_\_

Have you ever been treated by a chiropractor before: **Yes** or **No** If yes, date of last visit: \_\_\_\_\_ Name of previous chiropractor: \_\_\_\_\_

How would you rate your general stress levels? **None Minimal Moderate Great**

Are your complaints affecting your ability to work or otherwise be active?

Some restrictions (able to perform light duty work & household tasks)  No effect  
 Need limited assistance with common everyday tasks  Need assistance often  
 Significant inability to function without assistance  I am totally disabled (impaired and cannot care for self)

How much time do you spend? (please circle)

<b>Sitting</b>	Most of the day	Half of the day	A little of the day	None
<b>Standing</b>	Most of the day	Half of the day	A little of the day	None
<b>Computer work</b>	Most of the day	Half of the day	A little of the day	None
<b>Strenuous manual labor</b>	Most of the day	Half of the day	A little of the day	None
<b>Moderate manual labor</b>	Most of the day	Half of the day	A little of the day	None
<b>On the Phone</b>	Most of the day	Half of the day	A little of the day	None
<b>Driving</b>	Most of the day	Half of the day	A little of the day	None

Patient Initials: \_\_\_\_\_

Please List each area of your symptoms in order of severity. Then at the scale below, mark (X) at a point along the line that demonstrates the level of severity.

**Areas of Symptom**

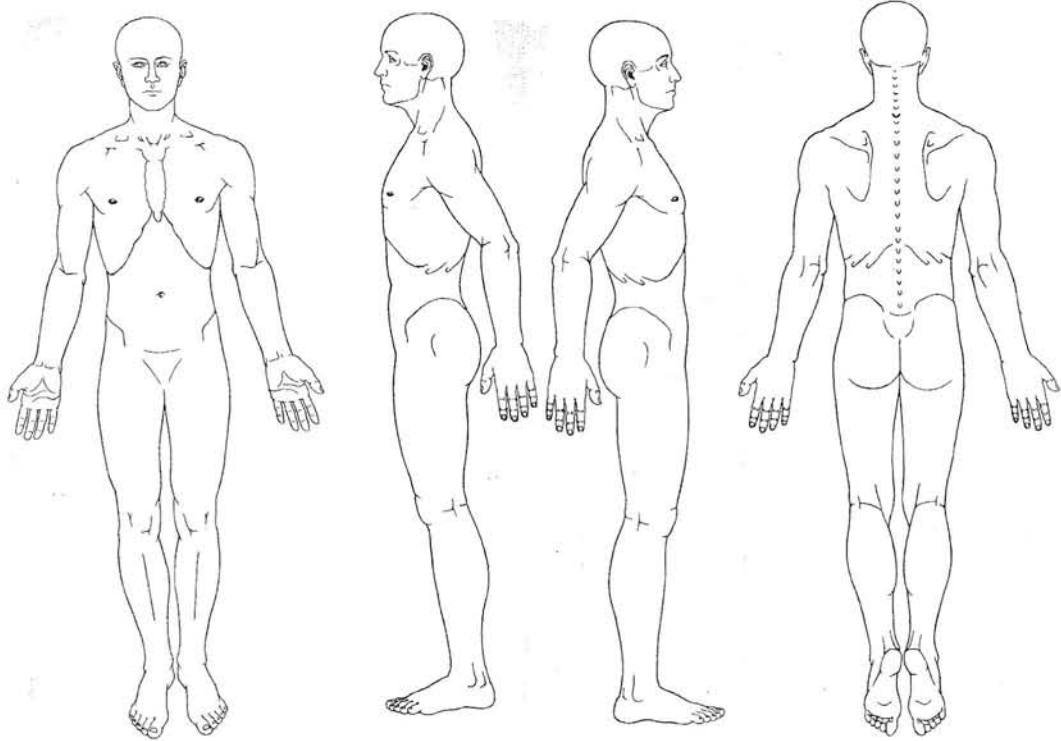
1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Severity**

No Pain or Symptoms											Worst Pain Imaginable										
0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10

In the area to the right please indicate where you are experiencing pain or symptoms by drawing in the letter abbreviations on the diagrams

**Sharp Pain = P   Stiffness = S   Tingling = T   Dull Pain = D   Numbness = N   Burning = B**



**Medical History**

Have you been treated for any other conditions in the last year? Yes No  
 If yes, please describe: \_\_\_\_\_

Date of Last physical exam: \_\_\_\_\_ Findings? \_\_\_\_\_

Have you had any dental care or minor surgery in the last 4 weeks? **Yes** or **No**

Are you, or do you think that you may be pregnant? **Yes** or **No** If yes, # of weeks: \_\_\_\_\_

**Patient Initials:** \_\_\_\_\_

Do you ever experience night sweats? Yes or No  
 Do you wear orthotics? Yes or No  
 Does weather affect your symptoms? Yes or No  
 Do you experience muscle spasm? Yes or No

**Please List Any:**                      **Date:**                      **Please describe:**

Motor Vehicle Accident		
Recent Work Injury		
Sports/Recreational Injury		
Falls or Other Traumas		
Surgeries		
Hospitalizations		
Other Medical Conditions		

Medication/Supplement	Dosage	Reason for taking	Taking since (date)

**Family Health History**

Family Members	Medical Conditions: Past and Present (IE: Heart Disease, Cancer, Diabetes, ect.)
Mother	
Father	
Sister	
Brother	

**Patient Initials:** \_\_\_\_\_

General Habits	None	Light	Moderate	Heavy
Coffee/Tea				
Tobacco				
Recreational Drugs				
Exercise				
Sleep				
Appetite				
Soft Drinks				
Water				
Salty Foods				
Sugary Foods				
Artificial Sweeteners				
Alcohol				

Do you have any difficulty with the following?

-Please place "N" in the space if the condition is Now

-Please place "P" if the condition was in the Past

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Abdominal Pain   | <input type="checkbox"/> Gall Bladder           | <input type="checkbox"/> Mental Disorders  |
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Gout                   | <input type="checkbox"/> Nausea            |
| <input type="checkbox"/> Allergy          | <input type="checkbox"/> Gynecological Problems | <input type="checkbox"/> Nervousness       |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Hardening of Arteries  | <input type="checkbox"/> Pneumonia         |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Hearing Problems       | <input type="checkbox"/> Poor Appetite     |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Heart Disease          | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Headaches              | <input type="checkbox"/> Sciatica          |
| <input type="checkbox"/> Chest Pain       | <input type="checkbox"/> Hemorrhoids            | <input type="checkbox"/> Short of Breath   |
| <input type="checkbox"/> Colds/Infections | <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Sinus Trouble     |
| <input type="checkbox"/> Colon Trouble    | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Sleeplessness     |
| <input type="checkbox"/> Constipation     | <input type="checkbox"/> HIV / AIDS             | <input type="checkbox"/> Stress            |
| <input type="checkbox"/> Depression       | <input type="checkbox"/> Indigestion            | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Kidney Trouble         | <input type="checkbox"/> Thyroid Trouble   |
| <input type="checkbox"/> Dizziness        | <input type="checkbox"/> Knocked Unconscious    | <input type="checkbox"/> Ulcers            |
| <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Liver Trouble          | <input type="checkbox"/> Varicose Veins    |
| <input type="checkbox"/> Fatigue          | <input type="checkbox"/> Lung Problems          | <input type="checkbox"/> Vision Problems   |
|   |   | <input type="checkbox"/> Weight Gain       |

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Dr. Michael Rintala DC, CSCS**

## **Financial Policies**

### **Payment Option: No Insurance (\$150 Initial Visit - \$85 regular visit)**

You agree to pay by cash, check, or credit card on the day that treatment is rendered. Unless we approve other arrangements in writing, the balance on your account is due and payable when the services are rendered, and is past due if not paid by the end of the week. \_\_\_\_\_ **(Initials)**

### **Financial Policy: Insurance**

#### **Payment Options:**

You agree to pay your deductible \$ \_\_\_\_\_ and/or your co-pay of \$ \_\_\_\_\_ and any out-of-pocket portions at the time services are rendered. You agree to pay by cash, check or credit card on the day that treatment is rendered. Unless we approve other arrangements in writing, the balance on your account is due and payable when the services are rendered. \_\_\_\_\_ **(Initials)**

#### **Insurance & Required Payments:**

Co-Payments and Co-Insurances are determined based upon the individual agreement between you and your insurance carrier. In most cases we are NOT a party to this contract. Coverage varies from policy to policy, and we will do our best to cooperate with your insurance assignment for the collection of payment of your healthcare as a courtesy to you. Although we may estimate what the insurance company will pay, it is the insurance company that makes the final determination of the eligibility for coverage and amount of coverage for your care. In the event that your insurance provider will not approve services rendered and deems them as non-covered, payment for our services will be your responsibility.

Non-covered services include services that are not covered by the Member's payor. Non-covered services may also include services determined by their Plan to be maintenance-type services. Dr Michael A. Rintala D.C. upholds the highest of ethical standards and will only bill for services provided. We will be happy to supply you with the documents you'll need for filing a claim with your insurance company, but please note that some of our services may not be reimbursable under your specific policy.

Any co-payments or co-insurance payments required by an insurance policy must be paid at the time services are rendered. You agree to pay any of the portions not paid by your insurance company. If for any reason any portion is NOT paid by my insurance (within 90 days), I agree to make arrangements for prompt payment of the bill in full, and understand that additional late fees may incur at 3% each month thereafter until paid. \_\_\_\_\_ **(Initials)**

#### **Missed Appointment Fees:**

Patients who do not show up for an appointment or cancel with less than 24 hours notice will be charged a fee of **\$25 per Chiropractic Visit, and \$20 fee per half hour of massage scheduled.** This fee must be paid before a new appointment is scheduled, or will be billed to your current account. Providing updates to any and all contact information are the sole responsibility of the patient. \_\_\_\_\_ **(Initials)**

#### **Credit History:**

We will report your account status to any credit-reporting agency such as a credit bureau for delinquent accounts. If your accounts become past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs, which are incurred. If we have to refer collection of balance to a lawyer, you agree to pay all lawyers' fees, which we incur, plus all court costs.

**Returned Checks:** There is a fee (currently \$25) for any checks returned by the bank.

**Waiver of Confidentiality:**

You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

**Transferring of Records:**

You will need to request in writing, and pay a reasonable copying fee (currently \$25) if you want to have copies of your records sent to another doctor or organization.

**Effective Date:**

Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

**Patient Name:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Responsible Party:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

(If not the patient)

**Date:** \_\_\_\_\_

# Del Mar Chiropractic Sports Group

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Del Mar Chiropractic Sports Group is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

### DISCLOSURE OF YOUR HEALTH CARE INFORMATION

#### Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

#### Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. If payment is not made as arranged, our office may utilize an outside collection agency, credit reporting agency or other means of collecting outstanding debt. Your file, containing protected health care information, may be reviewed by the designated collection agency or authority.

#### Workers' Compensation

If applicable, we may disclose your health information as necessary to comply with state Workers' Compensation Laws.

#### Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

#### Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

#### Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

#### Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

#### Deceased Persons

We may disclose your health information to coroners or medical examiners.

#### Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

#### Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

#### Marketing and Other Communications

We may contact you for marketing purposes, as described below: (example)

"As a courtesy to our patients, it is our policy to call your home on the evening prior to your appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on you answering machine or with the person answering the phone. No protected health information will be disclosed during this call other than the date and time of your scheduled appointment and a request to call our office if you need to cancel or reschedule your appointment.

#### Change of Ownership

In the event that Del Mar Chiropractic Sports Group is sold or merged with another organization, your health information/record will become the property of the new owner.

**Your Health Information Rights**

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Del Mar Chiropractic Sports Group is not required to agree to the restriction that you requested.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have the right to inspect and copy your health information.

You have a right to request that Del Mar Chiropractic Sports Group amend your protected health information. Please be advised, however, that Del Mar Chiropractic Sports Group is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason (s) and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information made by Del Mar Chiropractic Sports Group.

You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

**Changes to this Notice of Privacy Practices**

Del Mar Chiropractic Sports Group reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Del Mar Chiropractic Sports Group is required by law to comply with this Notice.

Del Mar Chiropractic Sports Group is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Richard Belsky, DC by calling this office at 858-481-0303. If Richard Belsky, DC is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

**Complaints**

Complaints about your privacy rights, or how Del Mar Chiropractic Sports Group has handled your health information should be directed to Richard Belsky, DC by calling this office at 858-481-0303. If Richard Belsky, DC is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to

DHHS, Office of Civil Rights  
200 Independence Avenue, S.W.  
Room 509F HHH Building  
Washington, DC 20201

This notice is effective as of \_\_\_\_/\_\_\_\_/\_\_\_\_

I have read the Privacy Notice and understand my right contained in the notice.

By way of my signature, I provide Del Mar Chiropractic Sports Group with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

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Patient's name (print)

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Patient's Signature

date

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Authorized Facility Signature

date

## Informed Consent for Chiropractic Treatment and Care

I hereby request consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible for) by the doctor or intern, affiliated with Dr Michael A. Rintala, D.C.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interests.

I have read, or have had this read to me, the above consent. By signing below I agree to the above, all allow the doctor or intern, affiliated with Dr Michael A. Rintala, D.C. to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for my future condition and for any future condition(s) for which I seek treatment.

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Patient's **PRINTED** Name

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Date

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Patient's Signature

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Guardian's Signature