CAMPBELLSVILLE CHIROPRACTIC
DR. SAM YODER, D.C.
101 Winston Way Suite B
Campbellsville, KY 42718

Dr. Sam Yoder, D.C.
605 E Maple Street
Campbellsville, KY 42718
(270) 789-0033

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Address:_____ **City** _____ **State:**_____ **Zip:**_____

Email address: _____@_____ **Phone Number** _____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked
Amount Smoked *(packs/day)*:_____ **Years Smoking:** _____

CMS requires providers to report both race and ethnicity **Social Security Number:**_____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Who is your **Primary Care Provider** (Family Doctor)? _____

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Patient Signature: _____ Date:_____

Do you currently have or have you ever had (all questions must be answered):

High blood pressure?	Yes ☐	No ☐
High cholesterol?	Yes ☐	No ☐
Diabetes?	Yes ☐	No ☐
A heart attack?	Yes ☐	No ☐
A stroke?	Yes ☐	No ☐
Known heart disease?	Yes ☐	No ☐
Rheumatic heart disease?	Yes ☐	No ☐
A heart murmur?	Yes ☐	No ☐
Chest pain with exertion?	Yes ☐	No ☐
Irregular heart beat or palpitations?	Yes ☐	No ☐
Lightheadedness or do you faint?	Yes ☐	No ☐
Unusual shortness of breath?	Yes ☐	No ☐
Cramping pains in legs or feet?	Yes ☐	No ☐
Emphysema?	Yes ☐	No ☐
Other metabolic disorders (thyroid, kidney, etc.)?	Yes ☐	No ☐
Epilepsy?	Yes ☐	No ☐
Asthma?	Yes ☐	No ☐
Back pain: upper, middle, lower?	Yes ☐	No ☐
Other joint pain (explain on back of form)?	Yes ☐	No ☐
Muscle pain or an injury (explain on back of Form)?	Yes ☐	No ☐
Have parents who died from a stroke, heart attack, or cancer:	Yes ☐	No ☐

To the best of my knowledge, the above information is true.

Signature _____

Date_____ Witness _____

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Name _____

☐ Check if you would like Dr. Yoder's Monthly Newsletter on Health Tips, Information, & Promotions via email (1-2 x month)

How did you hear about this office?

☐ Friend _____ ☐ Internet (website) _____ ☐ Other _____

☐ Referral from other Doctor _____ ☐ Advertisement (type) _____

NOTE: PAYMENT IS EXPECTED AT TIME OF VISIT

Do you have Insurance: ☐NO ☐YES Name of Insurance Company _____

Name of Person Responsible for Payment _____

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. As such, I authorize any charges for services submitted to my insurance company to be paid directly to the office of Campbellsville Chiropractic, LLC. Furthermore, I understand that Dr. Yoder's office will prepare any necessary reports and forms to assist me in making such collections from the insurance company and I agree that any amount authorized to be paid by my insurance company is to be paid directly to Dr. Yoder's office and will then be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment the day of service. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ **Date** _____

Guardian or Spouse Signature _____ Date _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this office has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Name (Print): _____ Relationship to the Patient:_____

Signature:_____ **Date**:_____

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All health care professionals including medical doctors, osteopathic doctors, chiropractic doctors and physical therapists that perform manipulation (adjustments) are required by law to obtain your informed consent before initiating treatment.

I, _____, do hereby give my consent to the performance of conservative, noninvasive treatment to the joints and soft tissue. I understand that the procedures may consist of manipulations (adjustments) involving movement of the joints and soft tissue. Therapeutic exercise, ultrasound, hot packs (or ice), TENS units and other therapeutic modalities may also be used.

Risks: Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are risks and complications associated with these procedures as follows:

Soreness: I am aware that, like exercise, it is common to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases of underlying physical defects, deformities, or pathological processes such as weak bones from disease, cancer or osteoporosis may render the patient susceptible to injury.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur between once per million to once per ten million treatments.

General Modalities: hot packs, ice packs and other adjunctive therapies used in tissue healing can, if used inappropriately, cause discomfort such as burns or pain. If this were to occur I understand that it should be reported to the doctor.

Positive Treatment Results: I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

Alternative Treatment: Reasonable alternatives to these procedures have been explained to me including rest, home therapy, over the counter medication, medical consultation, surgery and the absence of treatment altogether.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

_____ _____

Date **Patient Signature**

_____ _____

Date **Witness Signature**