New Patient Intake Form

Name: _____ Contact Phone: (___) _____

Address: _____ City / Zip _____

Referred by: _____ Birthday: _____ Occupation: _____

Main Complaint: _____

List any other complaints: _____

How and when did this condition happen: _____

Have you had this or similar condition in the past? (Yes) (No) When? _____ Getting worse? (Yes) (No) (Constant) _____

List surgical operations and year: _____

List present medications: _____

List Allergies: _____

Results you would like to obtain at this office: _____

Other Practitioners seen: (MD) (DC) (DO) (Therapist) (Acupuncturist) (Homeopathic) (Naturopath) (Kinesiologist) (Health Consultant) (other)

Doctor's name: _____ Doctor's name: _____

Email or phone: _____ Email or phone: _____

Diagnosis Offered: _____ Diagnosis Offered: _____

Treatment Results: _____ Treatment Results: _____

Would you like me to discuss your care with a practitioner listed above? (yes) (no) (I'll decide later).

Notice of Informed Consent: California Code of Regulations, Title 16, Div. 4, Article 2, Section 319.1 requires your acknowledgement of proposed risks relating to care at this office in the form of an informed consent by signature below. The procedures used in this office involve physical medicine commonly defined as skin surface reflexes, hard and soft tissue manipulation. Hard tissue manipulation (chiropractic adjustments) may be incorporated infrequently in the form of spinal, cranial, and or extremity manipulation. As a general rule hard and soft tissue manipulation, eye gaze and leg movement facilitate stimulation of neurogenic reflex activity of the central nervous system in an effort to correct and or stabilize neural pathways, organ function, muscular activity commonly called functional neurology.

Soft tissue manipulation steps are a combination of rubbing, stretching, and pinching type activities. Steps that are known to cause brief physical discomfort include stimulation of internal jaw muscles. This step is frequently employed on every visit. A clean finger cot is always used for this procedure. If you have a latex sensitivity please let me know.

I understand and agree that all services rendered are charged directly to me and that I am responsible for payment. I also understand that payment for these services is due at the time of service. A statement will be provided when requested and we will mail a statement to your insurance carrier if we have completed information.

Signature _____ Date: _____

I have verbally reviewed consent with patient. _____ Date: _____

Dr. Mitchell Corwin, D.C

It is the goal of this office to provide health care in a cost effective and efficient manner. To accomplish this, we utilize minimal staff and ancillary services. If you miss an appointment or fail to give us appropriate cancellation notice, there may be a fee. It is your responsibility to call and reschedule as well as schedule preventative /follow up visit(s) commonly every 4-6 months.

Please complete backside for Insurance Information

After completing please print or save as an Email attachment to (dr.corwin@comcast.net)

Insurance Information

The following insurance information is required to process your benefits claim. Incomplete information will necessitate me mailing the form back to you before it can be processed.

Insurance Company: ______________________________

Address: ______________________________

City / State /Zip: ______________________________

Insured Name [if other than yourself]: ____________________ Claims Person if known: ________________

ID number of Insured: ____________________ Group #: ________________

Has a claim for this illness or injury been previously submitted by another health care provider? (yes) (no)

Name of Provider: (optional) ______________________________

If your insurance has restrictions in coverage please list. If you are aware of any therapy procedural restrictions please let me know.

Insurance benefits coverage vary significantly from policy to policy and often with a reimbursement rate for chiropractic care at a predetermined and or usual and customary value. This benefits value can range from $25 to 80% coverage. We have seen an average reimbursement rate of approximately $45-$95 for our general office visit. Please note Medicare has a reimbursement rate of ~$23 and frequently denied. Medicare does not cover Examination (initial visit) only for therapy treatment related to an injury(s).

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Email Address: (optional): ____________________ We welcome email communication to request a billing statement, questions about your care or office policy. Please visit my website for additional information.

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Authorization for Care of a Minor

I hereby authorize care to be administered as deemed necessary to my child. Additionally, I recognize that I will have an ongoing opportunity to discuss concerns before during or after any therapy provided. Email correspondence is welcome.

Parent or guardian ______________________________ Date: ____________

Medicare Coverage (only)

If you have Medicare coverage and it is not assigned to another provider, all necessary forms will be completed and you will be reimbursed at the Medicare authorized value of ~$23 a visit. Please note that if you have additional coverage it will be automatically forwarded by Medicare to your secondary provider, (please list the secondary carrier above).

By my signature below, I fully understand that this provider is not accepting Medicare's assignment of benefits and that I am responsible for the full office visit fee. On request you will be provided with an Advance Beneficiary Notification (ABN) …a medicare form that lists options of care that can be performed by other providers. Please note medicare requirements are difficult to satisfy such that coverage is generally restricted to acute "accident/injuries" claims only.

Signature: ______________________________ Date: ____________

Thank you for choosing me to assist you with your health care needs!