HAGERSTOWN HEALTH, LLC
Chiropractic & Physical Therapy
1329 Pennsylvania Avenue
Hagerstown, MD 21742
Ph: 301-791-7111 F: 301-791-7119

Brenna Bacon Ranieli, DC
Matthew Ranieli, DPT

PATIENT INTAKE FORM

DATE: _____

NAME: _____
Last First Middle

ADDRESS: _____CITY: _____STATE: _____ ZIP: _____

EMAIL: _____

PREFERRED CONTACT PHONE #: _____ SECONDARY PHONE #:_____

DATE OF BIRTH: _____ AGE: _____ GENDER (Please circle): M / F LAST 4 DIGITS OF SSN:_____

IN CASE OF EMERGENCY CONTACT NAME: _____PHONE: _____

YOUR OCCUPATION: _____EMPLOYER:_____PHONE:_____

MARITAL STATUS: M S W D NAME OF SPOUSE: _____ NUMBER OF CHILDREN: _____

NAME OF PARENT/GUARDIAN (if patient is a minor):_____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

HAVE YOU EVER HAD CHIROPRACTIC CARE BEFORE? ___ Y / N_____ DOCTOR'S NAME: _____

PURPOSE OF THIS APPOINTMENT: _____

PAYMENT METHOD: (Please Circle) Self-Pay Health Insurance Personal Injury Protection Workers Compensation

INSURANCE COMPANY: _____ POLICY HOLDER name:_____ date of birth:_____

POLICY HOLDER ADDRESS if different than above: _____

IS THIS CONDITION DUE TO: AUTO ACCIDENT _____ WORK INJURY_____ OTHER_____ DATE: _____

IF THIS IS A RESULT OF ONE OF THE ABOVE, DO YOU HAVE A LAWYER? _____ YES_____NO

LAWYER'S NAME: _____PHONE: _____

ADDRESS: _____CITY: _____STATE: _____ZIP: _____

PRIMARY CARE DOCTOR: _____DATE LAST SEEN/REASON: _____

X_____
Patient Signature

Flip Over□□□□□□□□□□

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CONSENT FOR TREATMENT: THE UNDERSIGNED CONSENTS TO THE TREATMENT AND THE PROCEDURES, WHICH MAY BE PERFORMED, DURING THE RECOMMENDED CHIROPRACTIC AND/OR PHYSICAL THERAPY CARE.

RIGHT TO REFUSE TREATMENT: THE UNDERSIGNED UNDERSTANDS THAT HE/SHE HAS THE RIGHT TO MAKE AN INFORMED REFUSAL OF ANY TREATMENT THAT MAY BE CONSIDERED DURING OUTPATIENT CARE.

FINANCIAL RESPONSIBILITY: THE UNDERSIGNED AGREES, WHETHER HE/SHE SIGNS AS PATIENT, THAT IN CONSIDERATION FOR THE SERVICES TO BE RENDERED TO THE PATIENT HE/SHE HEREBY INDIVIDUALLY OBLIGATES HIMSELF/HERSELF TO PAY THE ACCOUNT, IN ACCORDANCE WITH THE REGULAR RATES AND TERMS OF THIS OFFICE. THIS OFFICE HAS A NO-SHOW POLICY IN WHICH A 24-HOUR NOTICE IS REQUIRED FOR SCHEDULE CHANGES AND/OR CANCELLATIONS. IF A PATIENT FAILS TO NOTIFY THIS OFFICE OR SHOW FOR A SCHEDULED APPOINTMENT, A FEE OF $50 WILL BE ASSESSED TO THE PATIENT'S ACCOUNT.

RELEASE OF INFORMATION: THE UNDERSIGNED DOES HEREBY AUTHORIZE THIS OFFICE TO RELEASE AND OBTAIN ANY AND ALL INFORMATION REGARDING THE PATIENTS MEDICAL HISTORY AND TREATMENT ADMINISTERED DURING OUTPATIENT TREATMENT, TO ANY PHYSICIAN OR HOSPITAL OR TO ANY INSURANCE COMPANY, EMPLOYER, LEGAL COUNSEL OR OTHER ORGANIZATION RESPONSIBLE FOR THE PAYMENT OF THE PATIENTS MEDICAL EXPENSES. IF THE PATIENT IS COVERED BY MEDICARE, THE UNDERSIGNED AUTHORIZES ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT THE PATIENT TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. THE UNDERSIGNED CONSENTS TO ALLOW MESSAGES TO BE LEFT ON THE PERSONAL PHONE NUMBERS PROVIDED BY THE PATIENT ON THE INTAKE FORM REGARDING FUTURE APPOINTMENTS.

ASSIGNMENT OF INSURANCE BENEFITS: THE UNDERSIGNED AUTHORIZES, WHERE HE/SHE AS AGENT OR AS PATIENT, DIRECT PAYMENT TO THIS OFFICE OF ANY INSURANCE BENEFITS OTHERWISE PAYABLE TO OR ON BEHALF OF THE UNDERSIGNED FOR CHIROPRACTIC AND/OR PHYSICAL THERAPY SERVICES. IT IS THE UNDERSIGNED'S RESPONSIBILITY TO SUPPLY THIS OFFICE WITH A REFERRAL IF REQUIRED BY HIS/HER INSURANCE AND IF NOT SUPPLIED THE UNDERSIGNED WILL BE RESPONSIBLE FOR PAYMENT. IT IS UNDERSTOOD BY THE UNDERSIGNED THAT HE/SHE IS FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY THIS ASSIGNMENT.

WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: THE UNDERSIGNED HAS REVIEWED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES AND A COPY WAS PROVIDED IF REQUESTED

BY SIGNING THIS FORM, I ADMIT THAT THE CONTENTS OF THIS FORM HAVE BEEN FULLY EXPLAINED TO ME AND I DO UNDERSTAND THE CONTENTS OF THIS FORM.

SIGNATURE (PATIENT, PARENT, or GUARDIAN) X_____**DATE**_____

Print Name_____ **Relationship (circle one): Self Parent Guardian**

Patient's Date of Birth_____