BAREFOOT REHABILITATION CLINIC
WE FIX YOUR FRUSTRATING PAIN

NEW PATIENT INTAKE FORM

Please fill out all information. We cannot begin the consultation until this form is fully completed.

Date: ___________

Patient's Full Name _______________________________________ How would you like to be addressed by our staff? ______________

Home Phone: ___(804)647-6699_________ Cell Phone: ________________________ E-Mail: _________________________________

□Male □Female Age: _________ Date of Birth: _______/_______/________

Address: ____ City: ____________________ State: _______ Zip: __________

□Married □Single □Widowed □Separated □Divorced Number of Children: ______ Ages: _____________

Occupation: ________________________________ Employer: _________________________ Business Phone: ____________________

Emergency Contact: ____ Relationship: ___________________________________

Phone: _______________ Address:______________________ City: _______________________ State: ________ Zip: ____________

Family Physician: ____ Address: ____

City: _________________________________ State: ____________ Zip: ________________ Phone: _____________________________

Whom may we thank for referring to you? ____

IF YOU HAD A MAGIC WAND, WHICH PAIN AREA WOULD YOU GET RID OF?

(Please don't circle your neck and lower back, we won't be able to help you with both AT THIS TIME)

What is the ONE PRIMARY AREA that hurts the most, for which you will be seen for today?

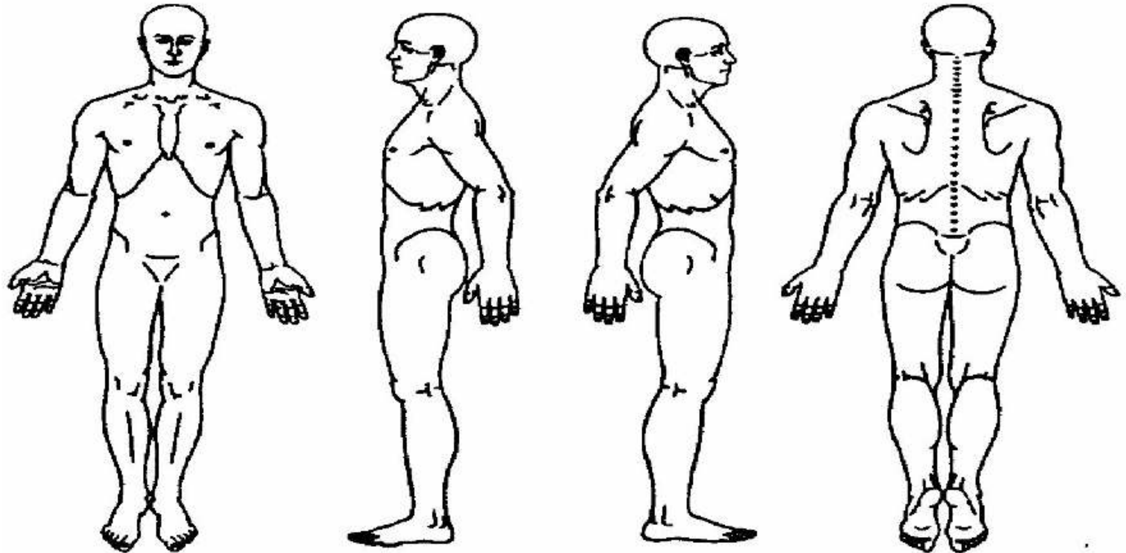
____

Use the following letters to indicate the TYPE and LOCATION of discomfort:

A - Aching
B - Burning
N - Numb/Tingling
P - Pins & Needles
S - Stabbing/Sharp
T - Throbbing
O - Other

How bad is the pain on a scale from 0-10 (0 = no pain | 10 = worst pain ever)

____



Do you feel pain sitting here, RIGHT NOW, WITHOUT MOVING, **at REST**? □Yes □No If yes, how intense is it from 0-10? _______

What makes the pain **WORSE**? ____

How long (in mins or hours) do you have to do the above activity before it gets **WORSE**? ____

The symptoms are:

- □ better as the day goes on
- □ worse as the day goes
- □ more prevalent at night
- □ more prevalent in the morning

If you feel it <u>more</u> in the morning, **how many minutes/hours** does it take until it gets better?______________________________

Does it interfere with your daily activities:

- □ minimal (annoyance, no impairment)
- □ slight (tolerated, some impairment)
- □ moderate (marked impairment)
- □ marked (preclude any activity)

What activities help the pain in the AM?____
____

What makes the pain **feel** BETTER? ____

What is your long-term goal from treatment (e.g. play a round of golf without pain)? ______________________________

What is your BIGGEST concern about your pain?

____

Do you want this pain gone? □Just now □Forever

Is there anything else I should know? ____

When did this pain episode **BEGIN** ? ___________________________ Was the **Onset**: □Gradual □Sudden

What **caused** the pain: □no apparent cause □one incident ______________________________________

Since the onset, has it gotten: □Worse □Stayed same □Better

Has this pain occurred before: □Yes □No How long ago since first occurrence? __________ months / years ago

What type of physical activity do you do? □Weights □CrossFit □Walking □Running □Spinning □Yoga

□Other ______________________ How many days per week do you exercise? ___________

What is your **athletic history** (middle, high school, college, post-college)? ______________________________

Secondary or related complaint(s) if any: ____

PAST INJURY/DISEASE HISTORY

Have you been treated for your **CURRENT** problem in the past? □Yes □No

If yes, when: _______________ If yes, by whom: ______________________________________

Outcome: □No effect □Somewhat better □Resolved

Have you been treated for **OTHER** problems in the past? □Yes □No

If yes, when: _______________ If yes, by whom: ______________________________________

Outcome: □No effect □Somewhat better □Resolved

Please list any major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries:

Date	Injury / Fracture / Illness / Surgeries / Falls	Treatment	Results

Please indicate any of the following illnesses you have had or currently have with approximate dates.

Hypertension	____________	Prostate Disease	____________	M.S	____________
Heart Disease	____________	Ulcer	____________	Headaches	____________
Stroke	____________	Allergies	____________	Cancer	____________
Diabetes	____________	Scoliosis	____________	Seizures	____________
Kidney Disease	____________	Mental/Emotional	____________	Auto Accident	____________
Fevers	____________	Upset Stomach	____________	Other	____________

What **medications** are you currently taking? ____

What **vitamins/supplements** are you currently taking? ______________________________________

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LIFESTYLE

How many nights per week do you drink **alcohol**? ________ On those nights, how many drinks do you have? __________

Do you smoke **cigarettes**? □Yes □No How much **mental stress** do you experience? □Mild □Moderate □Severe

How many hours of **sleep** do you get/night? ___________________ What time do you go to bed? _______________

Do you eat the following with every meal? **Vegetables**: □Always □Sometimes □Never
Animal Protein: □Always □Sometimes □Never

What did you have for **breakfast**? ____

Females only: Are you currently pregnant? □Yes □No

In general, would you say your health is (check one): □Excellent □Very good □Good □Fair □Poor

Signature of Patient: ____ ***Date***: __________________________

HIPAA NOTICE OF PRIVACY PRACTICES

YOUR HEALTH INFORMATION RIGHTS:
Unless otherwise required by law, your record is the physical property of the healthcare practitioner or facility that compiled it, but the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information and request amendments to your health records. You may also request a copy of your medical records at any time. This organization is required to maintain the privacy of your health information.

By signing this document, I **(PRINT NAME)** ____, acknowledge that I waive my right to privacy regarding the below individuals.

In order to give you the best care possible, we've found it helpful to connect with and send reports to other individuals close to you or healthcare providers who are serving you.

**I want you to send a report of my condition to the following people/providers: □Yes □No

I authorize my care/condition to be discussed with the following:

____
Name Relationship Phone Number

____
Physician's Name Field Phone Number

____
Physician's Name Field Phone Number

___________________________________ _____________________________________ ________________________
Patient/Guardian Name Printed **Patient/Guardian Signature** **Date**

___________________________________ _____________________________________ ________________________
Witness Name Printed Witness Signature Date

INFORMED CONSENT

Health care professionals are required to obtain your informed consent prior to treatment. Informed consent is the patient's legal right to know all the risks and benefits inherent to a medical procedure prior to agreeing to treatment.

I **(PRINT NAME)** ____, do hereby give my consent to have chiropractic care procedures performed. I understand that the procedures will consist of a precise form of manual therapy to soft tissues. I acknowledge that all health care procedures have some risks and complications, and that treatment has some limited, inherent risks that seldom occur. I have considered the following risks and complications regarding chiropractic care:

- **Soreness/Bruising**: It is common to experience localized muscle soreness and occasionally minor bruising in the treatment area.

I also understand the beneficial effects associated with these procedures including decreased pain, improved mobility and function, and increased quality of life. Reasonable alternatives have been explained to me including, rest, home applications of therapy, prescription or over-the-counter medications, exercises, and surgery.

By signing below, I now voluntarily and freely agree to have the chiropractic care procedures recommended and performed. I have had the opportunity to ask questions regarding the above information and possible consequences and risks. I have no further questions and I acknowledge that no guarantee of cure has been made to me concerning results and treatment.

____ ____________________
Signature of Patient Date

____ ____________________
Signature of Parent or Guardian (if patient is a minor) Date

____ ____________________
Signature of Witness Date

EXPECTATIONS FOR YOUR INVESTMENT

Most of our patients invest in their pain relief through our Case Fee Model. This has 4 benefits. 1) **It's Transparent** - You'll receive upfront pricing where you know exactly how much you're investing in your healthcare with no hidden costs. 2) **It's Aligned** - We both want you to be pain-free as fast and permanently as possible. 3) **It's Complete** - In this model, you'll finish care instead of getting 50% better like our patients used to, then quit, and come back in 12 months and they're worse so we have to start from scratch. We want to prevent that. 4) We want you to be HAPPY with our care. There is a **Refund Policy** if you should move, aren't satisfied, or can't comply with the treatment plan as seen below.

We accept Out-of-Network Chiropractic benefits. If you have insurance, we will verify your benefits in between your in person consultation and examination.Please send us a copy of the front and back of your insurance card via email (scheduling@barefootrehab.com).Please include yourinclude, your date of birth, and the primary insurance holder's name and date of birth, and we'll verify for you. If you are unable to do so, please bring in your insurance card the day of your consultation and we will take a physical copy. If we are able to use your insurance, you will pay $85 per visit.

If we decide to take you on as a patient after the Consultation and we diagnose you after the Exam, if you are being seen by the neck, mid-back or lower back doctors and we are unable to use your insurance, you'll be presented with a Case Fee Agreement ranging from $2,500 - $4,000 depending on the complexity of your problem. We have payment plans in place should you need one.

Treatment Expectation & Patient Responsibility (Part 1)

It is important to us that you understand what to expect when receiving treatment here at Barefoot Rehabilitation Clinic as you are trusting us to help you. We want you to be as pain-free as possible in the shortest amount of time. To do so, it is important to have consistent treatment and to follow the doctor's recommendations. We understand life happens and you may not be able to make it to all your scheduled appointments. We kindly ask that you reschedule your appointment as soon as possible.It is important to us that you receive treatment as consistently as possible to get you feeling better!

In order to provide you with the best care possible, it is our policy that:

1. If you can not come back into the office **within 1 month** of the recommended time the doctor would like you to come back:
    a. We will need to do a "Brief" exam which will take an additional 15 minutes so the treating doctor has ample time to re-establish where you are in the treatment plan, assess any setbacks that may have occurred over the past month and ensure we are doing our best to serve you from the correct starting point. This exam will carry an additional $85 along with the cost of your treatment.

    _____**Initials**
2. If you can not come back into the office **within 3 months** of the recommended time the doctor would like you to come back in:
    a. We will need to do an "Extensive" exam that will entail a brief history on what has transpired over the past 3 months along with a full assessment of your current symptoms, functional range of motion, and any orthopedic tests deemed necessary, to help confirm your diagnosis and establish your new base line. This will be a charge of $120 in addition to treatment costs.

    _____**Initials**
3. If you can not come back into the office **within 5 months** of the recommended time the doctor would like you to come back in:
    a. We will need to perform a new consultation ($65) and exam ($120) to identify and establish a new working diagnosis based on your recent history and symptoms, to ensure we are providing you with the best care possible!

    _____**Initials**

Patient's Signature:______________________ **Date:**________ **Witness:**________________________

Treatment Expectation & Patient Responsibility (Part 2)

RESPECTING TIME POLICY: If you are unable to keep an appointment, please give us a minimum of 24-hour notice. We do not want to charge for missed appointments, but it is an inconvenience for other patients who are trying to get in and see the doctor.

For any missed, rescheduled, or cancelled visit with less than 24-hours notice, you will be billed **$35***. **Patient's Signature**: _________________________ **Date**:____________ **Witness:** _________________

* We request your credit card information to be placed on file for the purpose of MISSED VISITS.

Authorization for Credit Card Use ☐missed visits

Name on Card: _____________________________ ☐ Visa ☐ MasterCard ☐ Discover ☐ Amex

Billing Address:____

Credit Card Number: ____ Expiration Date: __________

Card Identification Number: _________ (last 3 digits on back) Zip Code:_________ Amount to Charge: $__35___

I authorize Barefoot Rehabilitation Clinic to charge the amount listed above (or $35 for a missed visit) to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder signature:____________________________ Date: _______________

NOTE: Payment is due at the time of next service via cash, credit card, or check. We will always notify you before charging your card

Refund Policies

It is important to us at Barefoot Rehabilitation Clinic that you feel you are getting the value of our service we provide, permanent pain relief. A refund can be given for our services if you relocate, aren't satisfied, or cannot comply with a treatment plan as discussed with the doctor

Refund eligibility and reasoning:

- Patients who purchase a Case Fee, Care Packages, and the Pain Free and Happy course.

Care Packages:

A patient has **up to 1 months** from their **last time** in the office to receive a refund for treatment.
Refund will only be given for visits that are not used ____**Initials**

Case Fee:

Refunds will be allowed to be issued up to visit 15 in the treatment plan. The refund will be prorated from the case fee divided by the average number of visits (15) seen for each case.

____**Initials**

Pain Free and Happy Course:

Refunds will be allowed up through the end of the third week of the 10 week program. The Pain-Free & Happy Course has proven very effective for participants who participate and we insist on holding a high standard of success. The participation and progress of the participant will be assessed at the conclusion of the third week of the program by the participant and by Barefoot Rehabilitation Clinic. If no or very little progress is being made or the program is not being followed, a 70% refund will be issued. The participant can stop any time before that and get 80% after 2 weeks or 90% after 1 week.

____**Initials**

Non Refundable:

Consultation ($65) and Examination and Report of Findings ($120) are NOT refundable once completed.

____**Initials**

All patients who would like a refund MUST speak with one of our Patient Advocates first