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 Legal Name ____ How would you like to be addressed by our staff? ________________

Home Phone: ___________________________ Cell Phone: ____________________________ E-Mail: _________________________________

Gender _________________________________ Age: _________ Date of Birth: _______/_______/________

Address: ____ City: _____________________ State: _______ Zip: ___________

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

Occupation: ___________________________________ Employer:___________________________ Business Phone: ______________________

Emergency Contact: ____ Relationship: _____________________________________

Phone: _______________ Address:___________________________ City: ________________________ State: _______ Zip: _____________

Family Physician: ____ Phone: ______________________________

Address: ____City: ______________________ State: ______ Zip: ___________

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? (answer on line below)**

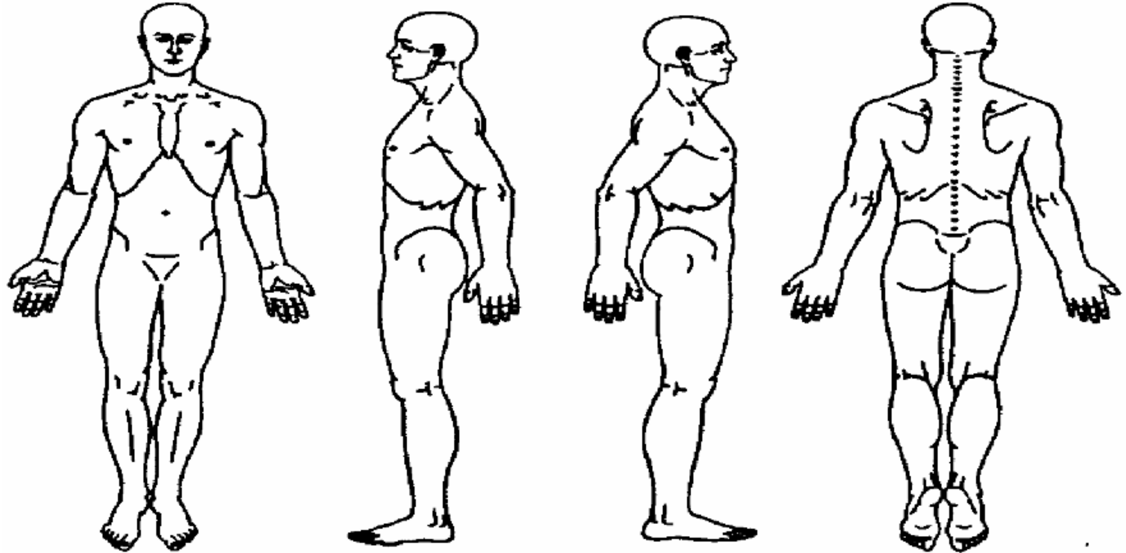
____

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, **at REST,** WITHOUT MOVING,?

□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 more 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 we 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 the same ☐Better

Has this pain occurred before: ☐Yes ☐No How long ago since the 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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PATIENT 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 many per day? ______ 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 or Parent/Guardian: ____ ***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 by law to maintain the privacy of your health information.

By signing this document, I **(PRINT NAME)** ____________________________________, acknowledge receipt of Barefoot Rehabilitation Clinic's HIPAA policy (cited above), and acknowledge my right to privacy, or the sharing of my records with 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. This authorization may be rescinded at any time by the patient or parent/guardian with written notice given to our office.

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

____
Name Relationship Phone Number

____
Name Relationship Phone Number

____
Physician's Name Specialty Phone Number

____
Physician's Name Specialty Phone Number

****Please sign below, regardless of whether or not you will be sharing information with your physician in order to acknowledge our privacy practices.**

________________________________ ________________________________ ______________
****Patient/Guardian Name Printed** **Patient/Guardian Signature** **Date**

________________________________ ________________________________ ______________
Office Staff Witness Name Printed **Office Staff 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 Barefoot rehabilitation Clinic's chiropractic care:

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

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 chiropractic care procedures that are recommended to me by Barefoot Rehabilitation Clinic to be 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 or 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 Office Staff 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 up-front 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 finish your care instead of getting 50% better like patients used to, then quit, and come back in 12 months feeling even worse, so we have to start again 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, cited below.

We may be able to accept your Out-of-Network Chiropractic benefits. If you have insurance, we will verify your benefits in between your in person consultation and subsequent examination appointments. Please send us a copy of the front and back of your insurance card via email (**scheduling@barefootrehab.com**). Please include your date of birth, as well as the primary insurance holder's name and date of birth, and we'll verify for you. If you are unable to do this prior to your Consult, please bring in your insurance card and photo at that time and we will make a photocopy. If we are able to use your insurance. you will be presented with our **Billing Agreement**. You may also opt for our **Case Fee Model**.

If your Consultation and Exam are with a Neck, Mid Back or Lower Back Doctor and you decide to proceed with treatment, and you are unable to use your insurance for any reason, you'll be presented with a **Case Fee Agreement** ranging from $2,000 - $4,000, depending on the complexity and severity of your case. We have payment plans in place, should you need one.

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Treatment Expectation & Patient Responsibility (Part 1)

In trusting us to help you, it is important to us that you understand what to expect when receiving treatment here at Barefoot Rehabilitation Clinic. We want you to be as pain-free as possible in the shortest amount of time. To do so, it is extremely important to have consistent treatment, and to follow the doctor's recommendations. We understand that 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, and with a minimum of 24-hour's notice. By initialing below, you acknowledge office policy regarding treatment expectations and patient responsibility

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:
   - We may 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 corrected starting point. This exam will incur an additional $85 fee, 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:
   - We may 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 in order to help confirm your diagnosis and establish your new base line. This will incur a charge of $150 or $225 (double extremity) 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:
   - We may need to perform a new consultation ($75) and exam ($150 or $225 for double extremity) 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 or Parent/Guardian Signature: ____ **Date**: _______________

Office Staff Witness Signature: ____ **Date**: _______________

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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**:____________

Office Staff Witness Signature: ____

We request your credit card information to be placed on file for the purpose of MISSED VISITS as well as Case Fee Installment Payments

Authorization for Credit Card Use ☐ missed visits Case Fee Installment Payment

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 $35 for a missed visit or for the agreed upon Case Fee Installment payment to the credit card provided above. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder signature:____ Date: _______________

REFUND POLICIES

It is important to us at Barefoot Rehabilitation Clinic that you feel you are getting the value of the permanent pain relief services we provide. 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 Applies to patients who purchase a Case Fee, Maintenance/Longevity Care Packages, and the Pain Free and Happy course.

Care Packages: ____**Initials**

A patient has **up to 1 month** from their **last treatment/scheduled visit** in the office to receive a refund for treatment.
Refund will only be given for visits that are not used

Case Fee: ____**Initials**

Refunds may be allowed to be issued up to visit 16 in the treatment plan. The refund will be prorated from the Case Fee divided by the average number of visits (16) seen for each case.

Pain Free and Happy Course: ____**Initials**

Refunds may be allowed up through the end of the third week of the 10 week program. The Pain-Free and Happy Course has proven highly effective for participants who participate, and we insist on upholding our 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 also by Barefoot Rehabilitation Clinic. If very little or no 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.

Non Refundable: ____**Initials**

Consultation ($75) and Examination and Report of Findings ($150, $185, or $225) are NOT refundable once completed.

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