ELEMENT
CHIROPRACTIC & WELLNESS

Welcome to Element Chiropractic & Wellness!

We are so excited that you have chosen us to help you achieve your health and wellness goals and to be part of your healing team. At Element, we put an emphasis on function and movement, aiming to identify the root cause of your symptoms. By doing this we can help to provide long term solutions and help you to achieve optimal health. We pride ourselves on working with you to accomplish your goals and on providing treatments specific to your needs.

At Element, our goals are the 3 E's: Enlighten, Engage, Empower. The three E's are crucial to long term success and optimal health for all those we care for.

Enlighten: We aim to enlighten our patients about the incredible healing power that our bodies are innately capable of and the role that both our minds and our bodies play in achieving optimal health.

Engage: We want to engage each patient in their treatment and encourage them to take on an active role in the process. It is important for both the doctor and the patient to be committed to making progress and achieving goals. We always encourage questions, feedback and conversations to keep our patients engaged in their own process.

Empower: We want all of our patients to feel empowered throughout their wellness journey. We do so by educating our patients on important health and wellness topics and by working with them to set goals and create treatment plans that meet their specific needs. We want those we work with to feel strong and capable of doing the things in life that bring them joy.

Healing is a process and takes on unique forms for each individual. We are here to help facilitate that process and to provide you the best care possible to help you heal and to live your most fulfilling life. In order to make that happen, we rely on your feedback. Did you experience something you loved or something that helped you immensely? We want to hear about it! Did you experience something that didn't seem to work so well or you did not enjoy? We want to hear about it! All feedback helps us to continue providing the best care possible for all of our patients and will ensure a positive environment for all. We thank you for trusting us with your care and look forward to joining you on your wellness journey!

In Health,

Dr. Sam

ELEMENT
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New Patient Intake

PERSONAL INFORMATION

PLEASE PRINT

First Name:_____ M.I._____ Last Name:_____ Preferred Name:_____

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

Birthdate:_____/_____/_____ Age_____ Gender: □ Male □ Female □ Unspecified. SSN:_____/_____/_____

Primary Phone:_____ Email Address*:_____

**By providing my email address, I authorize my doctor to contact me via the email address provided.*

Contact Method: (check one) □ Primary Phone □ Email

Marital Status: (check one) □ Single □ Married □Partnership □ Divorced □ Widowed

Spouse/Partner's Name:_____

Children?: □ Yes □ No How Many:_____ Have you had a C-Section? □ Yes □ No How Many:_____

Race: □ White □ Black/African American □ Hispanic/Latino □ Asian □Native American □Other:_____□

Ethnicity □ Hispanic or Latino □ Not Hispanic or Latino □ I choose not to specify

Occupation:_____ Employer:_____

Emergency Contact: (Name, Relationship, Phone #)_____

Family Physician Name:_____ City:_____

How were you referred to Element Chiropractic & Wellness?

□ Referred by:_____ □ Facebook □ Instagram □ Google Search □ Website
□ Community Event (specify which one)_____ □Other_____

INSURANCE OR PRIVATE PAY INFORMATION

Please provide insurance card(s) to front desk

Type of Insurance: □ Private Insurance □ Medicare □ Other_____

Primary Insurance Carrier:_____ Phone:_____

Policy#_____ Group #_____
Claim#_____

Name of Policy Holder:_____ Relationship to Patient:_____

Policy Holder's Birthdate :_____/_____/_____ Policy Holder's SSN: _____/_____/_____ Employer:_____

Is patient covered by another insurance? □ Yes □ No

Secondary Insurance Carrier:_____ Policy #:_____

ASSIGNMENT/AUTHORIZATION/RELEASE:

I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Element Chiropractic & Wellness, all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that "co pays" are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

□ **Private Pay/Cash:** By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered. Name of person responsible for this account:_____

X_____ DATE:_____

Signature of Patient, Parent or Legal Guardian (if minor)

REASON FOR VISIT

What is the reason for your visit today?: _____

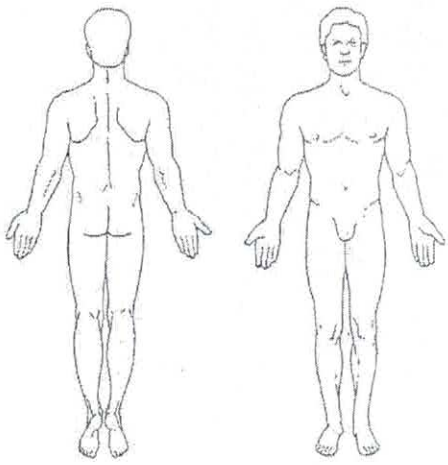
What caused this complaint(s)?_____

_____

When did this complaint begin?_____ Is it getting worse? □ Yes □ No □ Constant □ Comes and goes

Have you had this or similar complaint in the past? □ Yes □ No If "Yes"when?_____

What does your complaint(s) feel like? Circle all that apply:*Sharp / Dull / Sore / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness / Other*_____



←Please Circle or make an "X" on the body diagram to the left where you have pain or other symptoms.

Area for doctor's notes:

On the scale below, please circle the severity of your main complaint right now:

No Pain *Moderate Pain* *Worst Possible Pain*

0	1	2	3	4	5	6	7	8	9	10

What area(s) does the pain radiate, shoot, or travel to? (if applicable)?_____

What aggravates this complaint? Circle all that apply: Sitting / Standing / Walking / Getting up from seat / Walking stairs / Inactivity / Sleeping / Physical Activity / Exercise / Movement / Bending forward / Bending backward / Twisting / Reaching / Lifting / Desk work / Sneezing / Coughing / Everything / Unknown / Other:_____

What relieves this complaint? Circle all that apply: Sitting / Standing / Walking / Resting / Exercise / Movement / Stretching / Massage / Chiropractic / Heat / Ice / Laying down / Medication / Nothing / Unknown / Other:_____

How often do you experience your symptoms? □ 25% of the day □ 50% of the day □ 75% of the day □ 100% of the day

Timing of complaint: Check appropriate box: □ Morning □ As day progresses □ Afternoon □ Evening □ While sleeping □ During activities □ After activities □ Symptoms are constant and do not change □ Other:_____

With time are your symptoms: □ Improving □ Worsening □ Not changing

Have you seen other doctors for this complaint? □ Yes □ No If "Yes", please provide the following information:

Doctor's name:_____ Date consulted:_____Diagnosis_____

Is this condition interfering with your: (Circle all that apply) Sleep / Getting in or out of bed or chair / Personal care / Travel / Work / Recreation / Lifting / Walking / Standing / Daily Routine / Social Activities / Exercise / Other:_____

Is your complaint interfering with your daily activities? □ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

HEALTH HISTORY

Please check **ALL** of the health conditions below that apply to **you** currently or in the past.				**Family History** Mark **ALL** conditions that run in your family		Relationship: (Father,Mother,Sister,Brother)
□	Osteoarthritis/Degenerative Joint Disease	□	Whiplash Injury *Date of injury:*	□	Cancer *Type:*	
□	Asthma	□	Headaches	□	Anemia	
□	Diabetes □ Type I □ Type II Was your blood/lab work test for hemoglobin A1c > 9.0%? □ Yes □ No □ Not Sure	□	Joint Pain (circle location of pain): Shoulder, Elbow, Hip, Knee, Ankle Other:_____	□	Diabetes (check one) □Type I □ Type II	
□	Anemia	□	Migraines	□	Heart Problems / Stroke	
□	Cancer/Tumor	□	Osteoporosis /Osteopenia	□	High Blood Pressure	
□	Rheumatoid Arthritis	□	Epilepsy / Seizures	□	Genetic Disorders	
□	Depression/ Anxiety	□	Fibromyalgia / Chronic Fatigue	□	Rheumatoid Arthritis	
□	Disc Herniation	□	Genetic Disorders	□	Other (List):	
□	High Blood Pressure /Hypertension	□	Please list any other medical conditions:			
□	Heart Disease / Stroke					

WOMEN ONLY: Currently Pregnant? □ Yes □No □ Unsure **Painful /Abnormal Menstrual Cycle?** □ Yes □ No
Menopause? □ Yes □ No **Miscarriage?** □ Yes □ No **Do you have an IUD?** □ Yes □ No
Do you have children? □ Yes □ No If "Yes", have you had a C-Section? □ Yes □ No How Many:____

PAST INJURIES: (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date:)

_____
_____
_____

SURGERIES and/or HOSPITALIZATIONS (List and Date):

_____
_____
_____

Have you had an X-ray, CT scan, Diagnostic Ultrasound or MRI? □ Yes □ No

List current prescription medications, including frequency and dosage if known. If "NONE", check here □

Name of prescription medication	*Dosage/Start date*	4.	
1.		5.	
2.		6.	
3.		7.	

List any known allergies and your reaction:_____
_____
_____

If "NO" known allergies, check here □

List current vitamins and/or supplements you are currently taking, including frequency and dosage if known.

_____
_____
_____
_____

SOCIAL HISTORY
Height Ft. In. Weight: Lbs.
Do you exercise? □ Yes □ No Times per week? Intensity? □ Light □ Moderate □ Strenuous Type?:
Do you currently smoke tobacco of any kind? □ Yes □ Former smoker □ Never been a smoker If "Yes", how often do you smoke: □ Current every day smoker □ Current sometimes smoker Circle level below ↓: If "Yes", what is your level of interest in quitting smoking? (0 = NO interest, 10=very interested) 0 1 2 3 4 5 6 7 8 9 10
Do you drink alcohol? □ Yes □ No How many drinks per week? For how many years?
Do you drink caffeine? □ Yes □ No How many drinks per day? What type? □ Coffee □ Tea □ Soda Drinks □ Energy Drinks
Do you take pain killers? □ Yes □ No How often? □Daily □ Weekly □ Monthly □ Rarely What type? □ Aspirin □ Ibuprofen □ Tylenol □ Other_____
What do your work duties include? □ Sitting □ Standing □ Light Labor □ Heavy Labor □ Other:
Please describe your overall health right now? □ Excellent □ Very Good □ Good □Fair □ Poor
What is your current stress level? □ Mild □ Moderate □ High
Have you seen a chiropractor in the past? □ Yes □ No
What are your hobbies?

What are your top three goals in coming to Element Chiropractic & Wellness?

1. _____
2. _____
3. _____

ELEMENT CHIROPRACTIC & WELLNESS
NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which by law, or as dictated by - our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice please sign the bottom of this page and return to our front desk receptionist.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care
2. Inadvertent disclosures - an open treating area means open discussion… If you need to speak privately to the doctor please let our staff know so we can place you in a private consultation room
3. For payment purposes - to obtain payment from any insurance company or other available collateral source, OR
4. To obtain a recent address on you in the event you move and do not leave a forwarding address, we may use your 'emergency contact information' in whatever way necessary to locate you and collect any outstanding sums you may owe the practice/ doctor
5. For personal injury cases and workers compensation purposes - to process a claim or aid in investigation
6. Emergency- in the event of a medical emergency we may notify a family member
7. For public health and safety - in order to prevent or to lessen a serious or eminent threat to the health or safety of a person or general public
8. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person
9. For military, national security, prisoner and government benefits purposes
10. Deceased persons – discussion with coroners and medical examiners in the event of a patient's death
11. Telephone calls, emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events
12. Change of ownership - in the event this practice is sold the new owners would have access to your PHI

Note: **At any time, this office may update the list of ways your PHI may be used and all updates are deemed retroactive.**

YOUR RIGHTS:

1. To receive an accounting statement of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request restrictions on certain uses and disclosures and with whom we release information
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information, however like restrictions we are not required to agree to them

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information please call Dr. Samantha Brish at (248) 505-9170. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:
DHHS, Office of Civil Rights 200 Independence Ave. SW Room 509F HHH Building Washington DC 20201

I **understand that this** office reserves the right to amend this notice of privacy practice at a time in the future and will make the new provisions effective for all information that it maintains past and present. My signature below is an acknowledgement that I have received a copy of Element Chiropractic & Wellness' Patient Privacy Notice and I understand my rights as well as the practices to protect my health information. With my signature, I am conveying my understanding to the doctor. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient or Legal Guardian Name: _____

Patient or Legal Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

ELEMENT CHIROPRACTIC & WELLNESS
OFFICE POLICY AND INFORMED CONSENT

The best doctor/patient relationship is when there is complete understanding of the treatment and financial responsibilities between the doctor, staff and the patient. Our primary concern is being able to schedule you as required without creating a problem for you in keeping your account up to date. This will allow you to obtain the healthcare you need and handle your fees in a convenient manner.

Insurance

We shall assist in all possible ways to help you process and obtain all of the benefit for which you are eligible. We must emphasize as Chiropractic Care Providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, the financial obligation is yours and you are ultimately responsible for all charges. For your own information, please check with your insurance company as to the policy benefits to which you are eligible. We will advise you to pay any amount due for the "deductible", "copay" and/or any other "non-covered" charges.

Medicare

Our office will submit all Medicare services to Medicare. Patients who have Medicare benefits are required to pay their portion as services are rendered. Once the annual deductible has been satisfied, the patient will be responsible for the portion not covered by Medicare.

Personal Payment

Patients who do not have Chiropractic benefits included in their insurance coverage are expected to make payments at each visit. For your convenience we accept cash, personal checks, and most major credit cards. We will be happy to discuss your financial charges. This will allow you to obtain the healthcare you need and handle your fees in a convenient manner.

Payment Agreement

I have read and understand the Office Policy as it pertains to my financial responsibility. I understand that I am responsible for any balance due at the time that services are rendered. I am aware that if my account is past due by 30 days there will be a 1.5% finance charge added to my balance monthly. Should collection of services be required, fees for those services will be added to my balance and will be my responsibility. I also understand that I am responsible for all court costs and attorney fees should legal action be required. I agree that if I discontinue my care for any reason: 1) Any time of service or other house discounts will be voided. 2) I will pay the balance in full at the time.

Informed Consent

I hereby request and consent to chiropractic manipulation and other procedures including various modes of physical therapy, diagnostic x-ray, or tests Dr. Samantha Brish or her staff who now or in the future will treat me while employed by this office. I have had an opportunity to discuss with the doctor and/or with office personnel the nature and purpose of treatment indicated. I understand that results are not guaranteed and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including but not limited to fractures, disc injuries, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time is in my best interest. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by this office and/or employed staff.

_____ _____

Patient or Legal Guardian Signature Date

_____ _____

Witness Date

ELEMENT CHIROPRACTIC & WELLNESS
Waiver of Financial Liability

Dr. Samantha Brish of Element Chiropractic & Wellness has advised me that my insurance company does not reimburse the treatment I am having and/or it might not be considered medically necessary. I have advised Dr. Brish to proceed with the services and I will assume full responsibility for the payment, or portion not to be covered by my insurance.

I authorized direct payment to Element Chiropractic & Wellness and Dr. Samantha Brish. I am aware that I am responsible for any co-payments, co-insurance and deductibles for services that are covered by my insurance carrier.

Treatments:
Active Release Techniques (ART)
Instrument Assisted Soft Tissue (IASTM)
Cupping
Kinesiology Taping
Laser Therapy
Shockwave Therapy

_____ _____

Patient or Legal Guardian Signature Date

_____

Print Name

ELEMENT CHIROPRACTIC & WELLNESS
Cancellation & No-Show Policies

Enforcing a cancellation/no-show policy is one of the more difficult things for Element Chiropractic & Wellness to do. However, it is necessary to ensure the high level of care we strive to provide for all patients. We reserve your appointment time specifically for you. If you do not show up for your appointment or cancel at the last minute, it becomes both a lost opportunity for another patient to receive care and a financial loss for the practice. We understand that unanticipated events can happen in life, but we aim to be fair to all patients and maintain a reputable practice.

CANCELLATION & NO-SHOW POLICY

• Element Chiropractic & Wellness requires a 24 hour grace period for cancelling any appointment. This time allows us to schedule another patient to be seen during your scheduled time. If you cancel outside of this 24 hour window, you will be charged a $50 cancellation fee.

• If you forget your appointment or consciously choose to forgo your scheduled appointment time, you will be charged a $50 no-show fee.

LATE ARRIVALS

• If you are running late for an appointment, please call the office to let the doctor know. Depending on how late you arrive, your appointment may be shortened and end at the originally scheduled time in order to accommodate other patients whose appointments follow yours.

We thank you for your support of Element Chiropractic & Wellness and appreciate your cooperation, thank you!

_____ _____

Patient or Legal Guardian Signature Date

_____

Print Name