PATIENT INTAKE

Personal Information

Name:		Nick Name:	Date:	
SSN:	Sex: M F	D.O.B.:		
Address:				
City:	State:	Zip:		
Home Ph.:	Work Ph.:	Cell Ph.:		
Email:				
How were you referred to our office?		Marital Status: S M W D		
Number of Children (Name and ages):				
Employer:	Occupation:			
Give a brief description of your job duties:				
Emergency Contact:	Relationship:			
Cell Phone:	Work Phone:			
Smoking: Y N | Yrs.: # per day:	Drugs:	Monthly Alcohol (# of drinks):		
Chief Complaint(s):				
How and When did the problem begin?				
Is it getting worse?	What aggravates your condition?			
What treatment(s) have you had or tried for this problem?				
Does this condition interfere with work, sleep, recreation, daily routine, sex, etc?				
Primary Care Provider:				
List other Providers you have seen for this condition:				
Other Health Condition you are being treated for?				
What services are you interested in? *Provided under Medical Director Margit Winstrom MD				
O Chiropractic O Functional Nutrition/Medicine O Weight Loss O Food Allergy/Sensitivity O Anti-aging O Hormone Balancing O *Vitamin & Mineral Infusion/Shots O *Hyperbaric Chamber O Detoxification O Heavy Metal Clearance O Exercise with Oxygen Therapy (EWOT)				

Personal History

Unusual Childhood Diseases:	
Surgeries / Hospitalizations:	
Fractures/traumas (physical or emotional):	
Last Physical (date):	Findings:
Last Mammogram (date):	Last Coloscopy (date):
Medications	
Allergies to Medications?	
Vitamin or Supplements:	
Hobbies / Activities:	
Women, are you pregnant? Y N Not Sure	
Family / Friends / Co-Workers experiencing similar symptoms:	
Family History: Cancer, Diabetes, Heart disease, Alzheimer's, High blood pressure, Genetic conditions:	
Do you have trouble falling or staying asleep?	How many hrs. per night?
Do you toss and turn frequently?	How many times do you wake to urinate?
Do you wake tired in the morning?	Have you had a sleep study or wear a CPAP?

Review of Symptoms/Systems: Indicate if Present Now (N) or Previously (P)

Headaches/Migraines		Osteoporosis/Osteopenia		Weight gain or loss	
Back Pain (upper, mid, lower)		Loss of balance/dizzy/fainting		Memory loss	
Anxiety and/or Depression		Loss of smell		Ringing in ears	
Anemia		Loss of taste		Menstrual Issues	
Anorexia or bulimia		Unusual bowel patterns		Fertility Problems	
Asthma/ Breathing problems		Cold Feet or Hands or body		Miscarriage	
Fibrocystic Breasts / Lumps		Pacemaker		HIV/AIDS	
Shoulder / Arm Pain		Arthritis		Hepatitis B, C	
Hip / Knee /Ankle Pain		Muscle Spasms/cramps		Herpes (EBV, CMV, HSV1/2)	
Weakness in extremities		Frequent Colds and or fever		Arrythmia	
Sciatica		Prostate Problems		Epilepsy or Seizure	
Numbness or tingling		Sinus Problems		High Cholesterol	
High blood pressure		Diabetes		Spinal Disc Problems	
Difficulty urinating		Indigestion/ Reflux		Cancer	
Thyroid Problems		Constipation /Diarrhea		Alzheimer's/Dementia	
Kidney Disease		Autoimmune Disease		Other:	

Dietary Habits

Particular Dietary Pattern: Vegan, Vegetarian, Paleo, Ketogenic, Mediterranean, Standard American, Other_______________	Dietary Restrictions or Allergies:
How many meals per week do you prepare/cook at home?	
How often do you order out?	How often do you eat fast food?
Typical Dietary Intake: Indicate time and foods typically consumed. Time: Meal 1: Breakfast Time: Meal 2: Time: Meal 3: Lunch Time: Meal 4: Time: Meal 5: Dinner Time: Meal 6:	

Exercise/Fitness

Did you play sports ever in your life? Y N If yes, explain.
How many days per week do you perform: Cardiovascular Exercise: Resistance Training:
Other Exercise (e.g., yoga or stretching)?
How often do you perform breathing exercise, pray or meditate, etc?

Insurance Information: FOR CHIROPRACTIC ONLY

<table>
<tr><td colspan="4">Name of policy holder:</td></tr>
<tr><td colspan="2">Policy Number:</td><td colspan="2">Group Number:</td></tr>
<tr><td>SSN:</td><td>D.O.B.:</td><td colspan="2">Policy holder employer:</td></tr>
<tr><td colspan="3">Relationship to policy holder: Self Spouse Child Other</td><td>Flexible spending account? Y N</td></tr>
</table>

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned claimant, hereby authorize the release of any information relating to all claims for benefits on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this documentation authorizes Flux Metabolic Restoration Center, PLLC to submit claims for benefits, for services rendered or for servicesto be rendered without obtaining a signature on each and every claim to be submitted for me and/or my dependents, and that I will be bound by this signature as though the undersigned has personally signed the particular claim.

I hereby authorize my insurance company:____________________________________to pay and hereby assign directly to Flux Metabolic Restoration Center, PLLC all benefits, if any, otherwise payable to me for services as described on the detached forms, and I also agree to pay co-payments and/or deductibles.

I understand that I am financially responsible for all charges incurred and that any insurance benefits, when received by and paid to Flux Metabolic Restoration Center, PLLC will be credited to my account in accordance with the above assignment. I further acknowledge that verification of benefits is not a guarantee of payment from my insurance company.

Signature:	Date:

SPECIFIC RISK POSSIBILITIES ASSOCIATED WITH CHIROPRACTIC CARE

*Soreness – Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.
*Soft Tissue Injury – Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon, or other soft tissue injury.
*Rib Injury – Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.
*Vertebrobasilar Stroke – VBS is the most serious theoretical complication of chiropractic treatment. The most recent studies (Spine (Phila Pa 1976) 2009 May 15;34(11):E405–E413) estimate that the incidence of this type is injury is 0.05 to 1.46 per 10,000,000 manipulations.
*Other problems – There are occasional other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor immediately.

If during the course of chiropractic examination and/or treatment we encounter non-chiropractic or unusual findings, we will advise you. If you desire advise, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

I have read and fully understand the above statements.

Signature:	Date:

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic doctor has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature:	Date:

Flux Metabolic Restoration Center Policies

By signing below, you are acknowledging that you have read, understand and agree to the Flux Metabolic Restoration Center, PLLC policies.

- For Chiropractic Services, I understand that I may not be adjusted on the first visit and that diagnostic tests may be performed off-site.

- I understand the insurance coverage explained to me is NOT a guarantee of benefits, and I am responsible for any amount that my insurance company does not cover for chiropractic services.

- I understand that if I do not have insurance coverage or my insurance does not cover chiropractic or if I choose not to file on my insurance, I am responsible for the time of service discount cash prices which are as follows:

    - New Chiropractic Patient Office Visit: $175
    - Fees associated with the current Fee Schedule for each treatment or modality rendered
    - Patients not wanting to itemize their visits can opt to pay a flat service fee of $70 for any services deemed appropriate during this visit, so long as NO attempt at insurance reimbursement is made. This is a courtesy charge so we don't have to allocate administrative costs and time to dealing with your insurance company. If you decide at a later time you want to file, all fees will be re-entered under an insurance model and you will be required to pay the difference for the treatment. Insurance billed treatment is approximately $245 per visit.

- I understand that Functional Nutrition is NOT a covered service under ANY insurance. It is not reimbursable, there are no codes given for submission to any insurance. Functional Nutrition is a consult service and does not constitute a medical or chiropractic service and thus a doctor patient relationship is not established with this service. This service is not unlike seeing a nutritionist, health coach, or personal trainer. Medical records are only kept for services that establish a doctor patient relationship.
    - Functional Nutrition Consultations: $70 per each 20-minute interval.
        - First Nutrition Consultation: $210 - 280
        - Followup Nutrition Consultations: $140 - 210
- I understand that I am responsible for all charges incurred at Flux Metabolic Restoration Center including but not limited to supplements, products, services, and the 'no-call - no-show' policy.

- We enforce a 'no-call - no-show' policy, any patient missing an appointment without calling to cancel or reschedule prior to their appointment will be charged a $25 fee.

- I understand that cell phones can be very distracting in a doctor's office, and I agree to turn mine off or set it to silent when I am in the office. Cell phone calls are NOT allowed in the therapy bay.

- I understand that I will be charged a $25 returned check fee each time a check is return unpaid. I also understand that I will be charged $25 for any chargeback fees on credit card transactions.

- I understand that payment in full is due at the time services are rendered.

- We do not offer payment plans on supplements or lab testing; all must be paid in full at time of ordering, lab draw or purchase.

- If you are a Medicaid patient, please be advised that we do not accept Medicaid. You will be a private pay or cash patient and responsible for all charges incurred at this office.

- I give permission to Dr. Baca and/or the Flux Metabolic Restoration Center staff to leave messages at any of the phone numbers I have listed via voicemail or whomever answers. I also give permission for any correspondence to be mailed to my home address. Finally, I give permission for labs, and correspondence to be sent to the email provided, knowing that that commercial email services are not encrypted or secure.

Patient Signature:	Date:

Explanation of Insurance Coverage, Costs, and Out-of-Pocket Expenses for Chiropractic Services

Chiropractic care is considered a specialty field and benefits vary depending on circumstances such as the provider you choose, your group plan, and your individual benefits. It is your responsibility to know your benefits prior to your first visit at Flux Metabolic Restoration Center. It is also your responsibility to know if Dr. Baca is in-network with your insurance for chiropractic services. Specialty care is different than all other types of medical care coverage and it is your responsibility to verify that you have chiropractic coverage and what your coverage is. Please do not assume your out-of-pocket cost will be the same as it is for other specialty providers, even if a co-pay or co-insurance is listed on your insurance card or if FMRC staff assumes prior to verifying your benefits directly from your insurance company. We will verify your coverage details during your first visit. When you check out on your first visit, we will give you the total amount due for your first visit based on what your insurance company verifies is your coverage. If you would rather us verify your benefits prior to receiving any services, please feel free to ask us. Be advised that this may increase the time of your first visit. On your second visit, we will explain your expected out-of-pocket expenses for the entire recommended treatment plan after the doctor has reviewed your case history and any diagnostic testing needed. If your treatment plan changes, this will change your out-of-pocket expense. Our office will give you the most accurate information possible based on the information given to us by your insurance company.
However, the insurance EOB (Explanation of Benefits) is the final say in your coverage and your responsibility. If you do not have coverage or your coverage has been maxed out, you will be responsible to pay the time of service cash price per visit. Time of service cash prices per visit are as follows: $175 for the first visit, $70 for your treatment visits & any re-exam visits. If your benefits change during the duration of your treatment, you will be subject to the terms of your new coverage.

In addition, if we cannot verify benefits on your first visit because of problems with your insurance company, examples: offices closed, their computer is down, etc., you will be responsible to pay the cash price and you will be refunded any amount due on your second visit.

We will file your insurance claims with your insurance company. If your insurance company has not paid within 45 days, we will ask that you call your insurance company to ensure payment is made. If payment is not received in our office in 90 days, you will be responsible for paying the full balance due. If we receive payment from your insurance company, we will refund your money. If your account becomes 90 days past due, we will begin to assess interest fees at the rate of 5% per month for any and all balances.

All of the above insurance coverage, cost and out-of-pocket expenses apply to you, should you choose to start filing claims to your insurance, even if you start treatment as a cash/time of service discount patient and later choose to file on your insurance.

Patient Signature:	Date:

Pregnancy Waiver

I hereby acknowledge that Dr. Esaias Baca has informed me, prior to being x-rayed, the possible risks and consequences of receiving x-rays during pregnancy. I have stated on my own volition that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

Printed Name of Patient:	Date:
Signature of Patient or Authorized Representative:	
Witness:	Date: