NEW PATIENT WELCOME FORM

Welcome To McHugh Chiropractic & Healthcare

We are excited for the opportunity to support you on your journey to optimal health & wellness. The information requested provides insight into your current health situation and helps us in developing a treatment plan suited for your unique needs. Please complete and bring to your initial appointment, along with a Picture ID and insurance card.

CONFIDENTIAL PATIENT INFORMATION

Patient Name: _____ Nickname: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ Gender: _____Last 4 digits of SS#: _____

Phone Number: _____ Phone Carrier: _____

Email: _____

Occupation: _____ Place of Employment/School: _____

Status: (Please circle one)

Married Widowed Single Divorced Separated Partnered for ____ years Minor

McHugh Chiropractic has my permission to contact me by phone or email regarding any upcoming appointments and office updates or events. *(All information will remain confidential)* Circle Y / N

In case of emergency, please contact - Name: _____

Relationship: _____ Phone Number: _____

Whom may we thank for referring you?_____

INSURANCE INFORMATION

Insurance Company: _____

ID #: _____ Group#: _____

Subscribers Name: _____ DOB: _____

Relationship to Patient: _____

Assignment & Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Sean McHugh all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. The consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Guardian or Personal Representative | Relationship

_____ _____

Printed Name | Date

PATIENT CONDITION

Reason for today's visit: _____

When did your symptoms appear? _____ Is this condition getting progressively worse? Y / N

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): _____

Type of pain: *(circle all that apply)*

Sharp Dull Throbbing Numbness Aching Shooting

Burning Tingling Cramps Stiffness Swelling

How often do you have this pain? _____ Is it constant or does it come & go? _____

Does it interfere with any of the following? *(circle all that apply)* Work Sleep Daily Routine Recreation

Activities/movements that are painful to perform: *(circle all that apply)*

Sitting Standing Walking Bending Lying Down

What treatment have you already received for your condition? *(circle all that apply)*

Medication Surgery Physical Therapy Chiropractic Services None Other

Name of other doctors that have treated you: _____

SYMPTOMS CHECKLIST

Please indicate which of the following symptoms you experience. Circle all that apply for each symptom listed.

Back & Leg Pain

Pain In Your Lower Back:	Right	Left	Both	None
Pain In Your Buttocks:	Right	Left	Both	None
Pain Or Burning In Your Legs:	Right	Left	Both	None
Numbness Or Tingling In Your Legs:	Right	Left	Both	None
Weakness Or Loss Of Strength In Your Legs:	Right	Left	Both	None

Foot Pain

Pain Or Burning In Your Feet:	Right	Left	Both	None
Numbness Or Tingling In Your Feet:	Right	Left	Both	None
Increased Sensitivity To Touch On Your Feet:	Right	Left	Both	None
Trouble Feeling Hot Or Cold In Your Feet:	Right	Left	Both	None
Trouble Feeling Your Feet When You Walk:	Right	Left	Both	None
Discomfort Or Pain At Night In Your Feet:	Right	Left	Both	None

Hand, Finger Or Wrist Pain

Pain Or Burning In Your Fingers:	Right	Left	Both	None
Numbness Or Tingling In Your Fingers:	Right	Left	Both	None
Difficulty Gripping Things With Your Hands:	Right	Left	Both	None
Discomfort In Hands Wakes You At Night:	Right	Left	Both	None

HEALTH HISTORY

Please indicate the date of your last exam or test next to each:

Physical Exam: _____ Blood Test: _____ Urine Test: _____

Spinal X-Ray: _____ Spinal Exam: _____ Chest X-Ray: _____

Dental X-Ray: _____ MRI/CT-Scan, Bone Scan: _____

Circle Any Of The Following Conditions Below That You Have Experienced

Allergies/Asthma	Heart Disease	Pinched Nerve
Alcohol Use	Heart Pacemaker	Pneumonia Polio
Anemia	Hepatitis	Prostate Problems
Anorexia	Hernia	Prosthesis
Appendicitis	Herniated Disc	Psychiatric Care
Arthritis	Herpes	Rheumatoid Arthritis
Bleeding Disorders	High Blood Pressure	Rheumatic Fever
Breast Lumps	High Cholesterol	Scarlet Fever
Bronchitis	HIV Positive/ AIDS	Stroke
Bulimia	Kidney Disease	Suicide Attempt
Cancer	Liver Disease	Thyroid Problems
Cataracts	Low Blood Pressure	Tonsillitis
Chemical Dependency	Measles	Tuberculosis
Chicken Pox	Miscarriage	Tumors/Growths
Diabetes	Migraines	Typhoid Fever
Emphysema	Mononucleosis	Ulcers
Epilepsy	Multiple Sclerosis	Vaginal Infections
Fractures	Mumps	Venereal Disease
Glaucoma	Osteoporosis	Whooping Cough
Headaches	Parkinson's	Other: _____

Please any medications and/or supplements you are currently taking: _____

_____

For each of the questions below, please circle one answer

How often do you exercise? Never A Few Times Per Week Daily Other: _____

How would you describe the intensity of your exercise? Low Moderate Heavy

Do you engage in the following activities at work? Sitting Standing Light Labor Heavy Labor

Do you have any of the following habits? Smoking Alcohol Coffee/Caffeinated Drinks High Stress

Injuries/Surgeries You Have Had: (Please list a description with dates)

Falls: _____

Head Injuries: _____

Broken Bones: _____

Dislocations: _____

Surgeries: _____

X-RAY QUESTIONNAIRE

In most cases, X-rays are necessary to accurately diagnose and analyze your condition. We would like to confirm that you are not pregnant or aware of any other conditions at this time. By signing, you understand that there are risks associated with x-rays and that you give consent to receive x-rays if the doctor deems them necessary.

Patient Name: _____

Please check all that apply below. At least one box must be checked.

☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time.

☐ No. I am not aware of any medical condition I may have prohibiting me from x-rays.

☐ Yes, I have a medical condition prohibiting me from x-rays.

☐ I request that x-ray film not be taken at this time because: _____

_____ _____

Signature of Patient, Guardian or Personal Representative Date

_____ _____

Witness Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES

If you are completing these forms prior to your appointment at McHugh Chiropractic & Healthcare, please note that documentation will be provided at the initial consultation.

I, _____ , have reviewed/received a copy of McHugh Chiropractic & Healthcare's Notice of Privacy Practices.

_____ _____

Signature of Patient, Guardian or Personal Representative Date

OFFICE POLICES & FINANCIAL AGREEMENT

Treatment Plans

Welcome to McHugh Chiropractic & Healthcare. We are excited for the opportunity to support you on your journey to optimal health & wellness. The information received during your initial consultation and exam will be analyzed to develop a treatment plan suited to your unique needs. Please understand that the care plan created by Dr. McHugh is based on achieving the desired result in the shortest amount of time possible. Further, our treatment plans are designed to provide long term results. It is important to establish a foundation for reprogramming the body to function as it should. Without regular and consistent care, we cannot predict how patients will respond. If appointments are missed and not made up, it is unlikely that the patient will respond as desired and within the timeframe set.

Signing In

Upon arrival, please go directly to the front desk and sign in. You will be called and assigned a treatment room once the staff has prepared your chart for the doctor. Other patients may be called before you because of the particular services being received that day. In the event you sustain a new injury, please let the front desk know as soon as possible.

Appointment Scheduling

Advanced scheduling is recommended. We have found that scheduling 1 month in advance is most sufficient. We attempt to honor all appointments at their scheduled time to the best of our ability. If you are late or a walk-in patient, you may have to wait for the next available timeslot.

Cancellation/No Show Policy

Appointment times are reserved especially for each individual patient. If you are unable to keep an appointment for any reason, we require that you call immediately to reschedule your visit. In doing so, the doctor can offer that appointment to another patient. Patients must contact the office to cancel an appointment at least 24 hours in advance. If a patient fails to do so, a $25 service fee will be charged to the patient's account.

Make-up Appointments

Once a treatment plan is set up for you, it is very important that any missed or canceled appointments be made up within 48 hours to ensure continued improvement. We will do our best to work you into the schedule.

Insurance

McHugh Chiropractic and Healthcare accepts a number of health insurances and also has plans available for those who do not have health insurance. We require that all insurance, accident, or Worker's Compensation information be provided to this office within 3 business days of your initial visit. McHugh Chiropractic and Healthcare agrees to submit and receive insurance reimbursement for your care. As a courtesy to our patients, we will verify insurance benefits in our office. The insurance companies do not guarantee that the information we receive is accurate, therefore anything not covered will be the patient's responsibility.

Any service not covered by your insurance carrier is due at the time of service or in advance. If an insurance payment is sent directly to the patient, that payment shall be turned over to McHugh Chiropractic and Healthcare within 5 days of receipt. Medicare rules and regulations apply.

Financial Agreement

Please understand that you are fully responsible for all services provided to you and that you agree to pay for your portion of care. Payments will be made by the dates specified per the financial agreement and in concurrence with the care plan. You agree that in the event you fail to make payment in a timely fashion, payments will become due in full and could result in termination of care.

Billing

Outstanding patient balances will be billed monthly and considered past due 10 days after the invoice date or when special arrangements are not met. Returned checks are subject to a $35.00 fee. If your case is a personal injury case or workers compensation case and you decide to terminate care against your doctor's advice, the entire balance will immediately become due and payable.

_____ _____

Signature of Patient, Guardian or Personal Representative Date

_____ _____

Witness Date

INFORMED CONSENT TO CARE

A patient coming to the doctor gives his/her permission and authority to care for them in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

_____ _____

Patient's/Parent's or Legal Guardian's Signature Date

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc conditions, and rarely, fractures.

Prior to receiving chiropractic care at McHugh Chiropractic and Healthcare, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies needed. In addition, they will help us determine if there is any reason to modify your care and provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I understand and accept that there are risks associated with chiropractic care and give consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

This notice is effective as of _____ and will expire seven years after the date on which you last received services from us.

_____ _____

Patient's/Parent's or Legal Guardian's Initials Date

_____ _____

Witness Date