Archer Chiropractic

504-252-9182

Patient Intake

Date: _____

Please print or write legibly. Thank you!

Name: _____
First Middle Last

Preferred Name: _____ **Home phone:** _____

Cell phone: _____ **Provider: ATT**___ **Sprint** ___**T-Mob**___ **Other**_____

Date of Birth: _____ **Preferred Gender: M:** _____ **F:**_____ **O:**_____

Social Security: XXX-XX-_____ **Married:**_____ **Single:**___ **Partnered:**____ **Widowed:**_____

Email: _____

Address: _____ **Apt No.:**_____

City: _____**State:** _____ **Zip:**_____

Employer: _____

Position: _____

Emergency Contact _____ **Phone:** _____

Primary Care Physician: _____ **Phone:** _____

Are you pregnant? _____ **Do you have disk issues?** _____

Were you previously treated for your problem/injury? _____

***IS TODAY'S VISIT THE RESULT OF A MOTOR VEHICLE COLLISION?** _____ **Date of collision:** _____

Is today's visit the result of a work related incident? _____ **Date of incident:** _____

Who can we thank for your referral? **Google:** _____ **Yelp:** _____ **Sign:** _____ **Health plan**_____

Patient: _____ **Attorney:** _____

Someone/somewhere else: _____

PLEASE FILL OUT ALL PAGES

Payment required at time of service, thank you.

Below for office use only

Referral _____ L: _____ AA/PI: _____ E: _____ T: _____ O: _____ B: _____

4220 Canal Street . New Orleans, LA . 70119

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Appointment Reminders and Email Authorization

Archer Chiropractic Center and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your voicemail.

By signing this form, you are giving us authorization to contact you with these reminders and information.

Phone calls OK: _____

Cell phone provider: _____

Archer Chiropractic Center and members of the practice staff may use your name and Email address to inform you about treatment alternatives, or other health related information that may be of interest to you through your Email with our monthly newsletter.

If you decide to opt out of the Email newsletter there is an unsubscribe option in each newsletter.

This authorization will expire six years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above.

Emails OK: _____

PRIVACY PRACTICES ~ PATIENT RECEPTION FORM

I have received or reviewed the privacy practice notice (5 pages) for Archer Chiropractic Center, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

_____

Patient's signature Date

_____

Patient's name *(please print)*

_____

Minor/impaired patient's representative signature

_____ _____

Representative's relationship to patient Witness Date

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FINANCIAL RESPONSIBILITY/ INSURANCE ASSIGNMENT DISCLAIMER

Cash: If you do not have insurance you are responsible for payment for your chiropractic care. By signing this document you are accepting responsibility to pay for your care.

Insurance coverage: Archer Chiropractic Center is pleased to accept your insurance assignment. However, it must be understood that the contract with your insurance company is between YOU and YOUR insurance company. We will make every effort to file your insurance claim form and assist you in obtaining your rightful benefits. Please understand that YOU are fully responsible for any fees incurred, by you, and not reimbursable or collectable from YOUR insurance carrier.

Most carriers use the HCFA 1500 or CMS form**. It may be necessary for you to sign this form as an authorization to release information to your insurance company and authorizing your insurance company to pay the doctor directly.** We cannot submit anything to the insurance company unless you authorize us to do so.

Please remember that our office does not guarantee that your insurance company will make appropriate payments for your care. We will make every effort to verify coverage and collect what is due. **However, if for some reason your insurance claim is denied, or your co-pay/coinsurance is different from what we collect, you accept that you are responsible for the charges incurred at Archer Chiropractic Center**. You are always welcome to review our charges and receive copies of your bills and records.

Auto or other accident: If you were involved in an accident or have other litigation with an attorney, or you are filing individually without an attorney, your signature below authorizes us to put a Medical Lien against any proceeds from your case settlement to pay for your care.
If your case is faulty for any reason, you understand you are financially responsible for your care.

_____
Patient's signature Date

_____
Patient's name *(please print)*

_____
Minor/impaired patient's representative signature

_____ _____
Representative's relationship to patient Witness Date

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Informed Consent Form

I hereby request and consent to the performance of chiropractic treatments and other chiropractic/medical procedures, including various forms of physical therapy and diagnostic x-rays by **Archer Chiropractic Center, its' doctors and staff.** This consent is extended to other licensed chiropractic physicians, chiropractic assistants or licensed massage therapists, who now or in the future, are employed by, working with or associated with this office.

I certify that I have had the opportunity to discuss, with the doctor of chiropractic and/or other office personnel, the nature and purpose of the care that is being provided. I understand that the results are not guaranteed. Further, I have been informed and I understand that, as in the practice of any other healing arts, in the practice of chiropractic, there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I also understand that the doctor, who has explained all of these things to me, is not expected to be able to anticipate and explain all risks and complications. I will rely on the doctor to exercise appropriate judgment during the course of care, based on the facts known at this time, and in my best interest.

My signature below certifies that I have read, or have had read to me the above consent. I also certify that I have had the opportunity to ask questions and options to care have been explained. By signing this consent form, I agree to the care being provided to me for the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

Patient's signature Date	Witness's signature
Patient's name *(please print)*	Witness's name
Minor/impaired patient's representative signature	Doctor's signature
Representative's relationship to patient	Dr. Charles H. Archer, IV Doctor's name
	Date

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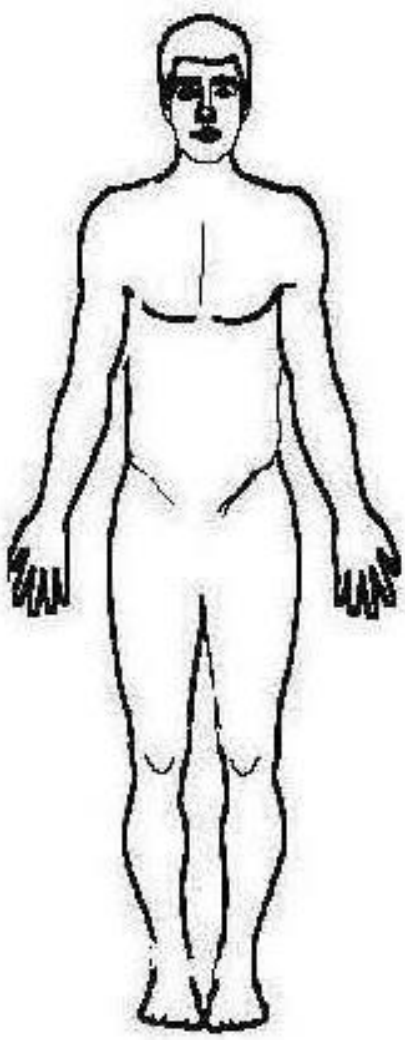
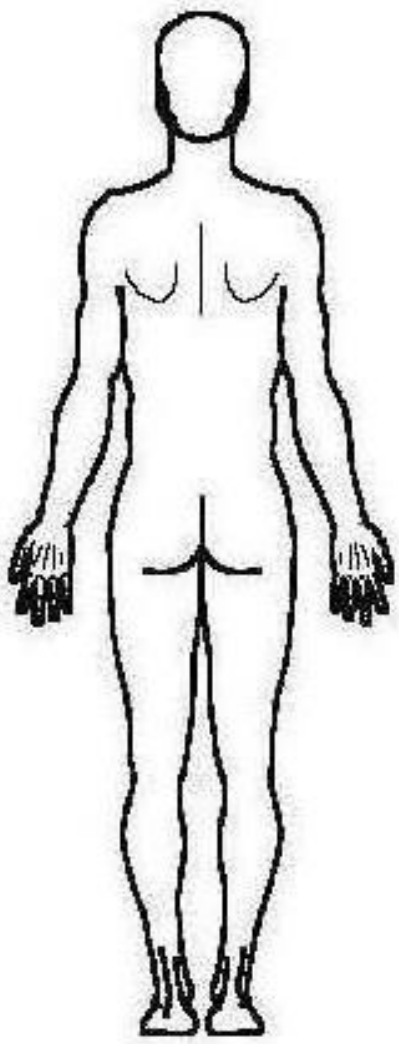
Reasons for Visit **Date:**_____

Name:_____ **Date of Birth:**_____

1. **Mark appropriate body part on a scale of 1 through 10 on the areas you would like the Dr to work on today.**





Weight: _____ **Height:** _____

Blood / Pressure / Pulse: _____/_____/_____

VACCN: ___ **BCBS:**___ **Aetna:** ___ **United:** ___ **Humana:** ___ **LSU 1st:**___ **CIGNA:** ___ **Gilsbar:** ___

Medicare: ___ **Medicaid:** ___**UHCCP:** ___ **CASH:** ___ **Hardship:**___ **Other:**_____