Simsbury Chiropractic & Wellness Center

Dr. Cheryl Vincent, D.C., DABCI

540 Hopmeadow Street., Simsbury, CT 06070

Phone: 860-651-3355 Fax: 860-408-9648

PATIENT INTAKE FORM

Today's date:_____

Name:_____ DOB:_____ Marital status:_____

Address:_____ City/State/Zip:_____

Home Tel:_____ Cell Tel:_____ Cell Carrier:_____

Employer:_____ Occupation:_____ Work Tel:_____

Employer's address:_____ SS#:_____

Nickname:_____ Email:_____

Spouse's name:_____ DOB:_____

Spouse's Employer:_____ Occupation:_____

Work Tel:_____ Employer's address:_____

Dependent's name(s):_____

IN CASE OF EMERGENCY, NOTIFY:_____ Tel:_____

Referred by:_____ Family Physician:_____

Who is financially responsible for this bill?_____

I will be paying for today's visit by: _____cash _____check _____credit/debit

INSURANCE INFORMATION:

Primary carrier/address:_____

Name of insured:_____ Relationship:_____ ID#:_____

Most current effective date:_____ Group #:_____

Secondary carrier/address:_____

Name of insured:_____ Relationship:_____ ID#:_____

Most current effective date:_____ Group #:_____

Do you need a REFERRAL for either of these policies? _____yes _____no PCP:_____

PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARDS AND YOUR DRIVER'S LICENSE SO THAT WE MAY MAKE COPIES FOR OUR FILES. Thank you.

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Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or a “pop” such as the noise when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscle strain, ligamentous sprain, dislocation of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risk occurring: The risks of complications due to chiropractic treatment have been described as “rare” about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in ten million and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

Other treatment options which could be considered may include the following:

- OTC analgesics. The risk of these medications include irritation to stomach, liver, and kidneys and other side effects in a significant number of cases.
- Medicare care, typically anti-inflammatory drugs, tranquilizers and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissues and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me. I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing chiropractic treatment. I have freel decided to undergo the recommended treatment and hereby give my full consent to treatment

_____	_____	_____
Printed Name	Signature	Date

Witness:

_____	_____	_____
Printed Name	Signature	Date

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Office hours:

Monday, Wednesday, & Thursday:	9am-6pm
Tuesday:	2pm-6pm
Friday & Saturday:	9am-12pm

Cancellations:

-If unable to keep an appointment; 24-hour notice is requested.
-For unforeseen emergencies or circumstances which necessitate cancellations, notification is requested as soon as possible.
-Missed appointments without notification will be billed to the patient for the time reserved.
-New patient appointments are typically 45-60 minutes. At the time of booking your initial consultation, we request a credit card on file to reserve the room for your visit. If you do not show up for your appointment, you will be charged the appointment fee of $100.00

Office hour calls:

-Calls to the Doctor during office hours will be answered by the receptionist who will take the message. The Doctor will return all phone calls within 48 hours. If it is an emergency, please notify the receptionist.

Insurance:

-We participate with **Anthem BC/BS, Connecticare, & United Health**
-We will submit claims for Cigna, Aetna, and Medicare patients, after payment has been made in full.

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

The signature below gives consent for treatment of the individual or minor for whom they are legally in charge, and that you have read and agree to the statements above.

May we leave a message on your answering machine or with the person answering the phone?

YES _____ NO _____ If yes, preferred phone number: _____

Email?:

YES _____ NO _____ If yes, preferred email address: _____

Patient/Guardian Name: _____

Patient/Guardian Signature: _____ Date: _____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I am requesting records of Doctor: _____

Name of facility or person: _____

Address: _____ City/State/Zip: _____

Telephone number: _____ Fax number: _____

THE PURPOSE FOR THIS RELEASE:

> You are hereby authorized to furnish Dr. Cheryl Vincent information from my medical records. Please photocopy all pertinent written documents for blood test results and Diagnostic reports for NO MORE than 1-2 years previous.

This authorization can be revoked in writing at any time, except to the extent that disclosure made in good faith has already occurred in reliance of the authorization.

I hereby release Dr. Cheryl Vincent any and all of her employees, agents managing members, and any of the attending physician(s) that I am requesting records of and/or from any and all legal responsibility or liability from the release of the above information to the extent authorized. *A copy of the authorization shall be valid as the original.*

I understand that there may be a fee for this service depending on the number of pages photocopied. If such a fee is to be paid, it shall be paid by me, the requestor and not Dr. Cheryl Vincent. However, no such fee is usually charged if these records are requested for continuing medical care.

Patient's Name: _____ D.O.B.: _____

Patient's Address: _____ City/State/Zip: _____

Patient's Telephone number: _____

Signature:_____ Date: _____

Please send a copy of all records to:

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