Connecticut
Disc & Laser Therapy Centers

NEW PATIENT INTAKE

Tell us what is bothering you - and what you want to get back to.

PATIENT INFORMATION

Full Name _____ **Today's Date** _____

Date of Birth _____ **Age** _____ **Sex** ◯ Female ◯ Male ◯ Other

SS # _____ **Marital Status** ◯ S ◯ M ◯ D ◯ W **Spouse Name** _____

Mobile Phone _____ **Email** _____

Street Address _____

City _____ **State** _____ **ZIP** _____ **Occupation** _____

How did you hear about us? ◯ Google ◯ Facebook / Instagram ◯ Friend / Family ◯ Existing Patient ◯ Doctor / Provider ◯ Attorney ◯ Apple ◯ Other

YOUR CONDITION

Main reason for your visit today _____

How long has this problem existed? _____ **Had this before?** ◯ Yes ◯ No

CURRENT SYMPTOM SNAPSHOT

Current intensity (0 = none, 10 = worst) ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

How much of the day? ◯ Constant ◯ Frequent ◯ Occasional ◯ Intermittent **Trend** ◯ Worse ◯ Better

How would you describe your symptoms?

- ◯ Dull ache
- ◯ Burning
- ◯ Tingling
- ◯ Throbbing
- ◯ Sharp
- ◯ Tightness
- ◯ Numbness
- ◯ Stabbing
- ◯ Radiating
- ◯ Shooting

What tends to make it worse?

- ◯ Sitting
- ◯ Bending / lifting
- ◯ Certain movements
- ◯ Weather
- ◯ Stress
- ◯ Standing
- ◯ Walking / activity
- ◯ Poor sleep
- ◯ Repetitive motions
- ◯ Other

WHAT YOU'VE TRIED & WHAT YOU WANT BACK

What have you already tried for this problem?

- ◯ Medication
- ◯ Injections
- ◯ Physical Therapy
- ◯ Chiropractic
- ◯ Surgery
- ◯ Stretching
- ◯ Massage
- ◯ Heat / Ice
- ◯ Acupuncture
- ◯ Nothing

What does this interfere with?

- ◯ Walking / running
- ◯ Exercise
- ◯ Standing
- ◯ Working
- ◯ Sitting
- ◯ Household chores
- ◯ Driving
- ◯ Personal care
- ◯ Sleeping
- ◯ Social activities

What would you most like to be able to do again?

_____

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PAIN MAP & HEALTH HISTORY

Medical history and treatment considerations

PAIN MAP

Mark the areas where you feel symptoms.

Mark symptoms directly on the figures.

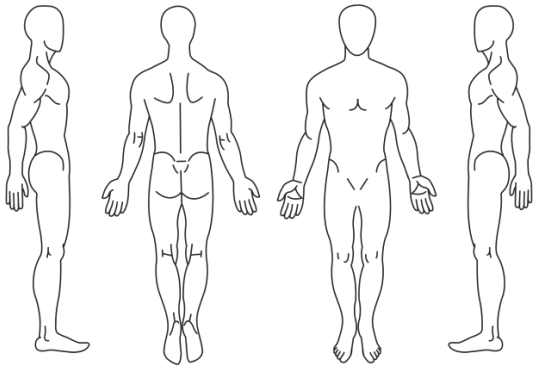
P = Pain

N = Numbness

T = Tingling

B = Burning

C = Cramping



HEALTH QUESTIONS

Are you pregnant?
◯ Yes ◯ No ◯ Unsure

Any implant, pacemaker, or electronic device?
◯ Yes ◯ No ◯ Unsure

Recipient of an organ transplant?
◯ Yes ◯ No ◯ Unsure

Taking blood thinners or statins?
◯ Yes ◯ No ◯ Unsure

If yes, identify device / condition: _____

MEDICATIONS & HISTORY

Allergies _____

Current medications (please list all medications)

_____

_____

Surgeries, major injuries / traumas, or hospitalizations (include approximate dates)

_____

_____

PAST MEDICAL HISTORY

Check all that apply.

- ☐ HIV / AIDS
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Aortic aneurysm
- ☐ Asthma / Allergies
- ☐ Back pain
- ☐ Cardiovascular issues
- ☐ Cancer
- ☐ Circulation issues
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive issues
- ☐ Dizziness
- ☐ Elbow / Hand / Wrist issues
- ☐ Endocrine issues
- ☐ Foot / Ankle issues
- ☐ Gout
- ☐ Headaches / Migraines
- ☐ Heart disease
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hip issues
- ☐ Immune issues
- ☐ Joint pain
- ☐ Knee pain
- ☐ Memory loss
- ☐ Lymphatic issues
- ☐ Multiple sclerosis
- ☐ Neck pain
- ☐ Osteoporosis
- ☐ Reproductive issues
- ☐ Ringing in ears
- ☐ Scoliosis
- ☐ Shoulder issues
- ☐ Stroke
- ☐ Thyroid problem
- ☐ TMJ issues
- ☐ Urinary issues
- ☐ Other _____

CONSENT & COMMUNICATION

I consent to allow Dr. Dalfino to speak with me and perform an examination (if necessary) in order to determine if I am a good candidate for treatment and a course of care. The questions on this form have been answered completely and truthfully to the best of my knowledge. Our office provides an appointment reminder service by email and SMS and may also communicate with you from time to time.

Signature _____ **Date** _____

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CONSENT AND ACKNOWLEDGEMENT

Treatment, financial policies, and acknowledgement

1. TREATMENT CONSENT & EXPECTATIONS

I _____ acknowledge Dr. Dalfino and the rest of the Connecticut Disc and Laser Therapy Centers staff has clearly explained the details of treatment. With my signature below I also give my consent to receive treatment and acknowledge that all of my concerns and questions have been expressed and competently and thoroughly answered by the doctor and/or staff. I understand the objectives of treatment being to relieve my pain and increase my mobility and my function. While it is expected that we will meet our objectives of improvement I also understand that nothing in healthcare is guaranteed. With a condition like mine, meeting these objectives may in fact not be possible and results, while unlikely, may be such that I may have no improvement at all or even feel worse. As such, I hold the doctor and/or staff completely harmless if expectations are not met. I am entering into treatment hopeful yet with the full understanding that my expectations may not be met and fully aware of the possible outcomes.

2. PAYMENT & FINANCING

Any and all treatment is expected to be payable at the time of service. If I choose to finance treatment, I understand that the financing is provided by a separate and distinct company unaffiliated with Connecticut Disc and Laser Therapy Centers. I have been informed and agree to the fact that my financing will be processed and paid in full on the day that I complete the financing paperwork regardless of when any scheduled appointments begin or end. Failure to be current with my payment may result in finance charges and/or treatment termination.

3. INSURANCE & MEDICARE

I understand that while Connecticut Disc and Laser Therapy Centers may or may not be in my insurance network it is possible I will not receive any insurance reimbursement for treatment, and I realize that this is purely a decision made by my insurance company. (This next statement is for Medicare recipients only... I have been informed by Connecticut Disc and Laser Therapy Centers staff that Medicare may not cover any of the services provided to me and therefore will not provide reimbursement. My signature below will serve as an appropriate ABN and NEMB forms, and I agree to be charged directly for uncovered services as agreed upon.) I understand that any insurance reimbursement is purely a decision of the carrier, and that I am ultimately responsible for any payment.

4. REFUNDS & PERSONAL ITEMS

All services paid for and received are non-refundable. Any services paid for but not completed are subject to a refund. Any and all supplementation, supports or DME are considered personal items and are considered non-returnable and non-refundable.

5. APPOINTMENTS & CANCELLATIONS

I understand and agree that any treatments, re-evaluations, consultations, meetings, exams, etc. scheduled with the doctor that are cancelled without a 24 hour notice, may be subjected to a $125 fee. Any missed appointment without any prior notification (No Call / No Show) will automatically be charged a $125.00 fee to the credit card on file. There are no exceptions to this policy. These appointment times are valuable and could have been made available to other patients who need care. Additionally, missed appointments without notice may cause unnecessary disruption to the clinic's schedule, including requiring staff to arrive earlier or stay later to accommodate other patients. In the event of a no call / no show, any and all of my future pre-scheduled appointments are subject to automatic cancellation, and it will be my responsibility to contact the office to reschedule. Following a no call / no show, future appointments will only be scheduled one at a time, at the discretion of the clinic. I agree to place a valid credit card on file and authorize the clinic to charge this card in the event of a no call / no show.

6. ACCOUNTS, COLLECTIONS & COMMUNICATION

I understand that in the event there is an issue arising regarding my account and financial responsibility to Connecticut Disc and Laser Therapy Centers, Dr. James J. Dalfino, At Best Chiropractic, LLC et. al – that in the event that my account becomes past due, the aforementioned will exhaust any and all measures to recover fees due the clinic. This may be in the form of collections, demand letters, or small claims. In the event that any or all of these measures are necessary, I agree that I will be held financially responsible for all fees incurred, whether I use outside financing or any office payment plan offered me. Chargebacks initiated by the patient in lieu of an arrangement and agreement made with the clinic will be subject to a $250 fee. By my signature below, I give Dr. Dalfino and the office consent to contact me via email, fax, and phone.

_____ _____

Patient / Client Signature Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT

Name of Patient: _____

I hereby acknowledge that I received a copy of this office's Notice of Privacy practices; I further acknowledge that a copy of the current notice is posted in the reception area, and that I may request a copy of any amended Notice of Privacy at each appointment.

SIGNATURE & CONTACT INFORMATION

_____ _____

Patient / Client Signature **Date**

_____ _____

Printed Name **Telephone**

If not signed by the patient, please indicate your relationship to the patient

_____

FOR OFFICE USE ONLY

- ○ Signed form received by: _____
- ○ Acknowledgement refused:

Efforts to obtain: _____

_____

Reasons for refusal: _____

_____