



EPOCH CHIROPRACTIC

n. [ep-uh k] 1. a point in time beginning a new or distinctive period.

5231 W. Woodmill Dr. Wilmington, DE 19808 | p: 302.635.7421 | f: 302.635.7422 | www.epochchiro.com

Patient's Name: _____

Today's Date: _____

How did you hear about us? _____

[Staff Notes: _____]

Patient Information **PLEASE COMPLETE ALL FIELDS (INDICATE "N/A" ON FIELDS THAT DO NOT APPLY)**

Address: _____

City: _____

State: _____ Zip: _____

Email: _____

Cell: _____ Home: _____

Work: _____

Sex: M F Age: _____ Birth Date: _____

Single Married Divorced Other

Patient Employer/ School: _____

Occupation: _____

Employer/ School Address: _____

Employer/ School Phone: _____

Spouse's Name: _____

Birth Date: _____

Spouse's Employer: _____

In Case of Emergency, contact:

Name: _____

Phone: _____ Relationship: _____

Primary Care Physician Information

Physician Name: _____

Practice: _____

Phone: _____ Date of last visit: _____

Reason For Visit: _____

Family Information

| Children's Name(s) | Sex(M/F) | Age |
|--------------------|----------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Insurance Information

Who is responsible for this account: _____

Relationship to patient: _____

Card Holders Birth date: _____

Is there additional/secondary insurance?

Yes No

----- [OFFICE STAFF] -----

Insurance Co. _____

Patient ID # _____ Group# _____

Patient Condition

Reason(s) for Visit (in order of main concern)

1. _____ **Check all that apply:** Sharp Dull Throbbing Numbness Aching Swelling
 Shooting Burning Cramps Tingling Stiffness Other: _____

2. _____ **Check all that apply:** Sharp Dull Throbbing Numbness Aching Swelling
 Shooting Burning Cramps Tingling Stiffness Other: _____

3. _____ **Check all that apply:** Sharp Dull Throbbing Numbness Aching Swelling
 Shooting Burning Cramps Tingling Stiffness Other: _____

Please circle all area(s) of concern:

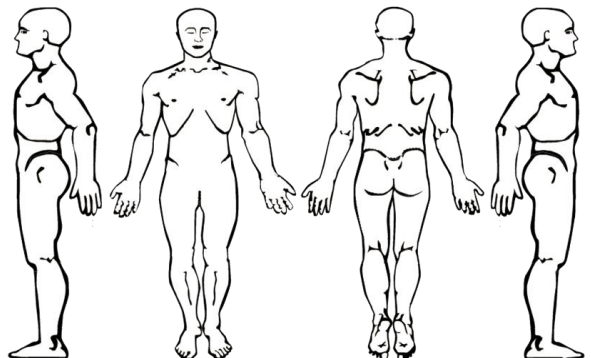
VAS: Please circle the number that BEST represents your condition

0 = NO pain

10 = Worst Possible Pain

|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|

0 1 2 3 4 5 6 7 8 9 10



Patient Condition Continued **PLEASE COMPLETE ALL FIELDS (INDICATE "N/A" ON FIELDS THAT DO NOT APPLY)**

Answer the following for your MAIN concern:

Is this a result of a car accident or injury at work? Yes (Date of accident/injury: _____) No

**** If yes, STOP and see staff. ****

When did your symptoms appear? _____

What do you believe caused this problem? _____

Is this condition: Getting Better Getting Worse Unchanged

Have you had this before? Yes No Last Occurrence? _____

How often do you have this pain? Constant Intermittent Only with certain movements/positions Random

What makes it better? _____

What makes it worse? _____

Does it interfere with your: Work Sleep Daily Routine Other: _____

Activities/movements painful to perform: Sitting Standing Walking Bending Lying Down Other: _____

Lifestyle **PLEASE CHECK ALL THAT APPLY**

| Exercise | Work Activity | Habits | Sleep |
|---|---|--|--|
| <input type="checkbox"/> None <input type="checkbox"/> Light/Sporadic <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy | <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor | <input type="checkbox"/> Current Smoker: _____yrs _____packs/day <input type="checkbox"/> Former Smoker: _____yrs / _____yrs quit <input type="checkbox"/> Alcohol (circle): social moderate heavy <input type="checkbox"/> Coffee/Caffeine: _____cups/day <input type="checkbox"/> Stress Level (0-10): _____ | <input type="checkbox"/> Average hours of sleep / night _____ <input type="checkbox"/> Trouble falling / Staying asleep <input type="checkbox"/> Restless Sleep Sleeping position: (check all that apply) <input type="checkbox"/> RT Side <input type="checkbox"/> LT Side <input type="checkbox"/> Stomach <input type="checkbox"/> Back |

DESCRIBE TYPE(S) OF EXERCISE: _____

Health History

Name and phone number of other doctor(s) who have treated you for your condition: _____ NONE

Last time you were seen by a Doctor of Chiropractic? _____ N/A

What treatment have you already received for your condition? Medications Surgery Physical Therapy Massage
 Chiropractic Services NONE Other: _____

Please list all injuries/surgeries you have had:

Description:

Date:

Car Accident(s): _____

Falls: _____

Head Injuries/Concussions: _____

Broken Bones/Fractures/Dislocations: _____

Surgeries (provide additional list if >3): _____

Please mark "Yes" or "No" to indicate if you have had any of the following:

| | | | |
|---|---|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No AIDS / HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No Diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No Herniated Disc | <input type="checkbox"/> Yes <input type="checkbox"/> No Osteoporosis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Alcohol / Drug Abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No Eczema | <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No Eating Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No Parkinson's |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No Irritable Bowel Syndrome | <input type="checkbox"/> Yes <input type="checkbox"/> No Pinched Nerve |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy / Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease / Stones | <input type="checkbox"/> Yes <input type="checkbox"/> No Pneumonia |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Fibromyalgia | <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Polio |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Autoimmune Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent colds/ Infections | <input type="checkbox"/> Yes <input type="checkbox"/> No Low Blood Sugar | <input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric Disorder |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Back Pain / Injury | <input type="checkbox"/> Yes <input type="checkbox"/> No Gallbladder Issues/stones | <input type="checkbox"/> Yes <input type="checkbox"/> No Lyme Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatoid Arthritis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No Measles | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No Menopause | <input type="checkbox"/> Yes <input type="checkbox"/> No Ringing in Ears |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chicken Pox | <input type="checkbox"/> Yes <input type="checkbox"/> No Hashimoto's | <input type="checkbox"/> Yes <input type="checkbox"/> No Menstrual Issues / PMS | <input type="checkbox"/> Yes <input type="checkbox"/> No Skin Disorder(s) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cold Sores | <input type="checkbox"/> Yes <input type="checkbox"/> No Headache / Migraine | <input type="checkbox"/> Yes <input type="checkbox"/> No Miscarriage | <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Constipation | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease / Attack | <input type="checkbox"/> Yes <input type="checkbox"/> No Multiple Sclerosis | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Problem |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Celiac Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No Mumps | <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No Hernia | <input type="checkbox"/> Yes <input type="checkbox"/> No Neck Pain / Injury | <input type="checkbox"/> Yes <input type="checkbox"/> No Venereal Disease (STD) |

Others not listed above: _____


Medication (provide additional list if > 4)

| Medications | Allergies | Vitamins / Supplements |
|--------------------------------|--------------------------------|--------------------------------|
| **MARK N/A IF NOT APPLICABLE** | **MARK N/A IF NOT APPLICABLE** | **MARK N/A IF NOT APPLICABLE** |
| 1. _____ | 1. _____ | 1. _____ |
| 2. _____ | 2. _____ | 2. _____ |
| 3. _____ | 3. _____ | 3. _____ |
| 4. _____ | 4. _____ | 4. _____ |
| Pharmacy Name: _____ | | Phone: _____ |
| Address / Location: _____ | | |

Family Health History

****PLEASE CHECK ALL THAT APPLY****

| Condition/Disease | Family Member/Relation | Condition/Disease | Family Member/Relation |
|---|------------------------|---|------------------------|
| <input type="checkbox"/> Alzheimer's/ Dementia: | _____ | <input type="checkbox"/> Liver Disease: | _____ |
| <input type="checkbox"/> Anxiety: | _____ | <input type="checkbox"/> Migraines/Headaches: | _____ |
| <input type="checkbox"/> Arthritis: | _____ | <input type="checkbox"/> Obesity: | _____ |
| <input type="checkbox"/> Autoimmune Disease(s): | _____ | <input type="checkbox"/> Osteoporosis: | _____ |
| <input type="checkbox"/> Blood Clotting Problems: | _____ | <input type="checkbox"/> Psychiatric Disorders: | _____ |
| <input type="checkbox"/> Celiac Disease: | _____ | <input type="checkbox"/> Thyroid Disorder: | _____ |
| <input type="checkbox"/> Depression: | _____ | <input type="checkbox"/> Heart Disease: | _____ |
| <input type="checkbox"/> Diabetes: | _____ | <input type="checkbox"/> Stroke: | _____ |
| <input type="checkbox"/> High Blood Pressure: | _____ | <input type="checkbox"/> Cancer (list all types): | _____ |
| <input type="checkbox"/> High Cholesterol: | _____ | | _____ |
| <input type="checkbox"/> Inflammatory Arthritis: | _____ | | _____ |
| <input type="checkbox"/> Kidney Disease: | _____ | <input type="checkbox"/> Other: | _____ |

 **Check here if NONE of the above apply**

List family member and age at death (if deceased): _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Epoch Chiropractic may prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Epoch Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I understand that I am responsible for all attorney fees or collection fees related to the collection of my account. I agree to pay interest at the rate of 1.5% per month (18% per annum) on any unpaid balance.

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and potential for improvement.

Signature: _____ Date: _____



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CREDIT CARD ON FILE POLICY

We are committed to providing you with exceptional care, as well as making our billing processes as simple and efficient as possible. Effective **Wednesday, July 20th, 2022**, Epoch Chiropractic will require *all* patients keep an active credit card on file with our office before treatment is rendered. Your credit card information will be kept confidential and secure. If you have any questions about this payment method, do not hesitate to ask our front desk.

By signing this form, I understand and agree with the following:

- I authorize Epoch Chiropractic to charge the credit/debit card provided ("the Card") for all outstanding balances, including but not limited to:
 - Deductibles, co-payments, and co-insurance amounts
 - Self-pay fee schedule amounts
 - No-show/cancellation fees
 - Other administrative fees
 - Any balance remaining after insurance reimbursement related to services provided to the patient.
- I certify that I am an authorized signer for the Card with all necessary rights to authorize the charges.
- I must keep this card information current in this office. Cards denying could incur additional fees and Epoch Chiropractic may decline to provide new services until payment is received.
- I may keep my HSA card on file, however, Epoch Chiropractic may require an additional card to be kept on file should the funds in the HSA account become insufficient.
- If a billing error has occurred with my insurance company, Epoch Chiropractic will refund any money owed to me once the dispute/error is settled.
- If the amount billed to the Card will be over \$200, Epoch Chiropractic will provide a courtesy call and/or email to let me know they will be charging the Card and/or to establish a payment plan.
- This form is valid until I give a 30-day written notice to cancel the authorization to Epoch Chiropractic

VISA Master Card American Express Discover

Card Number: _____ - _____ - _____ - _____

Expiration Date: _____ / _____ CVV: _____

Patient Name: _____

Name as it appears on the Card: _____

Card Holder's Signature: _____

Date of Authorization: _____



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INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art, which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. **Health is a state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.**

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name

Signature

Date

Doctor signature

Date

Minors only:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Parent/Guardian Signature

Date

Females only: Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

Signature

Date



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ASSIGNMENT, LIEN, AND AUTHORIZATION OF INSURANCE BENEFITS AND ATTORNEY

Provider Name: Dr. Himani Patel, D.C.
Clinic: Epoch Chiropractic
Address: 5231 West Woodmill Dr. Ste 45, Wilmington, DE 19808

To whom it may concern:

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Eternal Health LLC, doing business as Epoch Chiropractic, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor or clinic's expense.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Patient: _____

Date: _____

Epoch Staff: _____

Date: _____



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NOTICE OF PRIVACY PRACTICES

The privacy of your medical information is important to us and we are committed to protecting it. This notice describes how information about you may be used and disclosed, as well as, how you can get access to this information. Please read this information carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations. These include emergency care, quality assurance activities, payment, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a written request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law. We have the right to make changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services.

Complaints

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe your privacy rights with respect to confidential information in your medical records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of a complaint to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints on line at the government's website: <http://www.hhs.gov/ocr/hipaa>.

Contact Person

All questions concerning this Notice or requests made pursuant to it should be addressed to:

Privacy Officer
Eternal Health LLC at Epoch Chiropractic
5231 W. Woodmill Dr.
Wilmington, DE 19808
302.635.7421

I, Hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____

Date: _____

Effective Date: This notice is effective October, 1 2011 and applies to all protected health information contained in your medical records maintained by us.



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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____

DOB: _____

I hereby request and authorize: **Epoch Chiropractic – Eternal Health, LLC**

To disclose information to:

To receive information from:

Provider/Office: _____

Phone/Fax: _____

Information to be disclosed will include copies of:

Entire Record

All Imaging Reports/CDs

Progress Notes

Physical Exam Forms

Daily Chart Notes

Lab Results

Other: _____

HIV/AIDS testing, drug and alcohol information, and psychological/psychiatric studies will be included in this request unless otherwise indicated: Do not release

Purpose of Request:

Continuation of Care

Patient Request

Other: _____

I understand this authorization will be effective for **six months after the date signed**, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation.

I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, and that it may be re-disclosed by the recipient.

Signature of Patient or Representative

Date

Witness

Date