Gabbert Medical
120 E. Main Street, Suite B |Payson, Az 85541
P: 928-472-2225 | **F:** 928-468-0002
www.GabbertMedical.com

NEW PATIENT INTAKE FORM

(Patient Demographic)

Patient Name: _____ Nick name/AKA: _____
Date of Birth: _____ Age: _____ Gender: _____ Male _____ Female Number of Children: _____
Address: _____ City: _____ State: _____ Zip: _____
Cell phone: _____ Home phone: _____ Best contact #: ☐ Cell ☐ Home
How did you hear about us? ☐ Online Search ☐ Social Media ☐ Magazine/Newspaper ☐ Current Patient ☐ Other _____
Email Address: _____ (*for appointment or billing information*)
Marital Status (please check): Single Married Separated Divorced With Partner Widow(er)
Occupation: _____ Employer: _____ Hrs per week: _____
Employer's phone number: _____ Highest level of education: _____
Emergency contact's name: _____ Relationship: _____
Emergency contact phone number: _____ (Secondary number): _____
Regular Physician: _____ Phone number: _____
Height: _____ Weight: _____ Nationality: _____

(Medical History)

Have you previously received Chiropractic Care? ☐ Yes ☐ No When? _____

Please note when and why you had any of the following done:

X-Rays: _____
MRI/Cat Scans: _____
Ultrasounds: _____
Blood Work: _____

List any past surgeries and/or hospitalizations:

1. _____ 3. _____
2. _____ 4. _____

**List any surgically implanted/removed screws, plates, devices etc:

1. _____ 3. _____
2. _____ 4. _____

List any past medical diagnosis and/or treatments:

1. _____ 3. _____
2. _____ 4. _____

Please email the completed forms to info@gabbertmedical.com
OR print the completed forms and bring them to your appointment.

(Medications/Allergies)

Do you take medication daily: ☐ Yes ☐ No

If yes, what kind, how often and what dosage?

1._____ _____times a day. Dosage:_____

2. _____ _____times a day. Dosage:_____

3._____ _____times a day. Dosage:_____

**Are any of the medication(s) you take anti-inflammatories or anti-coagulants? ☐ Yes ☐ No

Are you currently under any medication at this time? ☐ Yes ☐ No

Please List All Sensitivities/Allergies/Reactions

Drugs: _____

Foods: _____

Environment: _____

**Have you ever been diagnosed with or treated for active cancer? ☐ Yes ☐ No

**At this time, are you currently sick or fighting off any viral infection(s)? ☐ Yes ☐ No

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(Self Assessment)

What is your primary health complaint? _____

How long has this complaint been present? Years _____ Months _____

What are your symptoms? _____

Do you experience pain or discomfort? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 (0 never - 10 all the time)

(Please circle)

What treatments have you tried that have **NOT** worked? _____

_____

Indicate areas of your life affected or restricted due to your complaint:

__ Home __ Work __ School __ Sports __ Hobbies __ Family/Kids __ Sex Life __ Relationships

__ Vehicle Operations __ Outdoor Activities __ Shopping __ Social Activities __ Pet Care __ Hygiene

__ Travel __ Physical Fitness __ Hunting Other: _____

Due to my primary health complaint:

My overall stress level has:	☐Increased	☐Decreased	☐No Change
My ability to sleep well has:	☐Increased	☐Decreased	☐No Change
My daily energy level has:	☐Increased	☐Decreased	☐No Change
My current quality of life:	☐Increased	☐Decreased	☐No Change

How important is renewing your quality of life? 0 1 2 3 4 5 6 7 8 9 10

(0 not urgent - 10 absolute must)

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HEALTH QUESTIONNAIRE

MUSCULO-SKELETAL
_____ Low back problems
_____ Pain between shoulders
_____ Neck problems
_____ Arm problems
_____ Leg problems
_____ Swollen joints
_____ Painful joints
_____ Stiff joints
_____ Sore muscles
_____ Weak muscles
_____ Walking problems
_____ Broken bones

CARDIO-VASCULAR RESPIRATORY
_____ Chest pain
_____ Pain over heart
_____ Difficulty breathing
_____ Persistent cough
_____ Coughing phlegm
_____ Coughing blood
_____ Rapid heartbeat
_____ Blood pressure problem
_____ Heart problems
_____ Lung problems
_____ Varicose veins

NERVOUS SYSTEM
_____ Numbness
_____ Loss of feeling
_____ Paralysis
_____ Dizziness
_____ Fainting
_____ Headaches
_____ Muscle jerking
_____ Convulsions
_____ Forgetfulness
_____ Confusion
_____ Depression

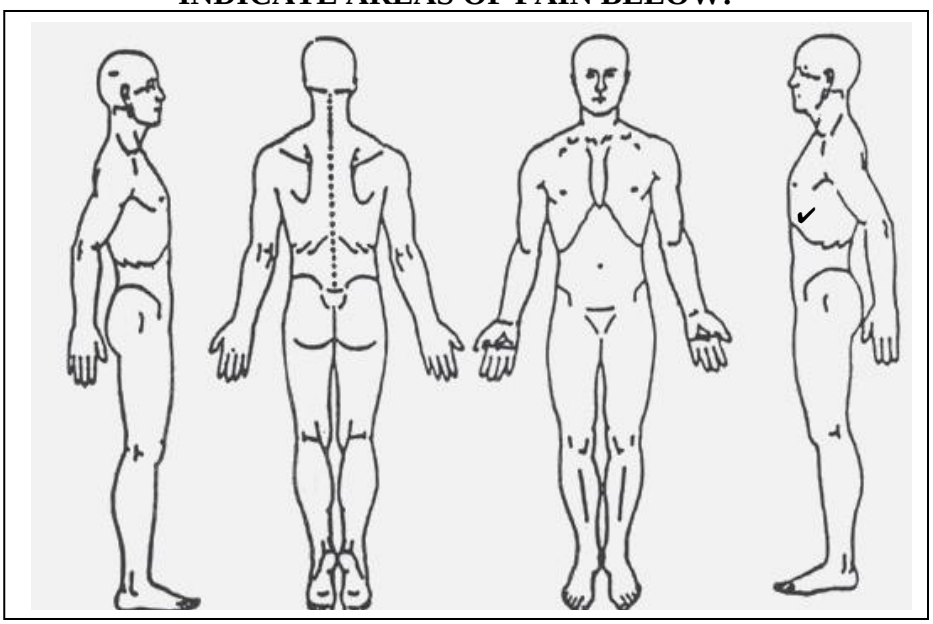
GENITO-URINARY
_____ Bladder trouble
_____ Excessive urine
_____ Scanty urination
_____ Painful urination
_____ Discolored urine

FEMALE
_____ Vaginal discharge
_____ Vaginal bleeding
_____ Vaginal pain
_____ Breast pain
_____ Lumps on breast(s)
Are you pregnant/nursing?
_____Yes _____No

GASTRO-INTESTINAL
_____ Poor appetite
_____ Excessive hunger
_____ Difficulty chewing
_____ Difficulty swallowing
_____ Excessive thirst
_____ Nausea
_____ Vomiting food
_____ Vomiting blood
_____ Abdominal pain
_____ Diarrhea
_____ Constipation
_____ Black stool
_____ Bloody stool
_____ Hemorrhoids
_____ Liver trouble
_____ Gallbladder problems
_____Weight trouble

EYES, EARS, NOSE & THROAT
_____ Eye strain
_____ Eye inflammation
_____ Vision problems
_____ Ear pain
_____ Ear noises
_____ Hearing loss
_____ Ear discharge
_____ Nose pain
_____ Nose bleeding
_____ Nose discharge
_____ Difficult nose breathing
_____ Sore gums
_____ Dental problems
_____ Dental problems
_____ Difficult speech

INDICATE AREAS OF PAIN BELOW:



OTHER HEALTH CONCERNS:

_____
_____
_____
_____
_____
_____
_____
_____

Patient Print Name: _____ **Date:** _____

Patient Signature: _____

Parent/Guardian Signature required if patient is under the age of 18.

Please email the completed forms to info@gabbertmedical.com
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CONSENT TO TREAT FORM

CHIROPRACTIC TREATMENT

Chiropractic care is a non-surgical, non-invasive procedure and has one of the safest records in health care. As with any healthcare specialty, we cannot promise a cure but we will give you our best care and we will discuss any questions or concerns with you.

Patients may experience temporary symptoms such as an increase in soreness following a massage, manipulation or traction. In addition, physiotherapy such as ice, heat or ultrasound may irritate the skin. There have been a few cases where adjustments may have aggravated a bulging or herniated disc or caused a rib fracture. On extremely rare occasions, adjustments to certain areas of the cervical spine have been related to a compromise of the vertebral artery and possible stroke symptomatology.

I acknowledge that I have discussed non-surgical Chiropractic care and physiological therapeutics and by signing below I authorize Gabbert Medical to provide such care.

NATUROPATHIC TREATMENT

Naturopathic care focuses on holistic medical treatment and proactive prevention of diseases. By using protocols that minimize the risk of harm, naturopathic physicians help facilitate the body's inherent ability to restore and maintain optimal health.

Care provided by the doctors and staff at Gabbert Medical encompasses routine diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work, intravenous therapies, injection procedures, acupuncture, structural manipulation and administration of medications/supplements prescribed by the doctor.

I agree to treatment using, but not limited to, nutrition, lifestyle, homeopathy, herbs, acupuncture, aesthetic, hormones, pharmaceuticals, nutraceuticals (supplements), intravenous and injection therapies.

I understand and am informed that, as in the practice of naturopathic medicine/integrative medicine, there are some risks to treatment, including, but not limited to: pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching, loss of consciousness, allergic reactions to prescribed herbs, supplements, medications, aggravations of pre-existing symptoms.

MEDICAL RECORDS PROTOCOL

Gabbert Medical is in accordance with Arizona State Law maintains medical records for a period of at least six (6) years after the last treatment date. Minor patient's records are maintained for a period of at least three (3) years after the child's 18th birthday or for at least six (6) years after the last treatment date, whichever occurs later. Gabbert Medical has a protocol for the secure storage, transfer, disposal and access of medical records at our office. By singing below I acknowledge that I have been provided a copy of the ***Medical Records Protocol*** for Gabbert Medical and is available to me at any time upon request.

RECORD RELEASE

I understand that my records and X-Rays may be released for professional consultations to other health providers as necessary. Gabbert Medical routinely sends many X-Rays and related health care information to Diagnostic X-Ray Consultation Services for interpretation. Should additional consultations be required with other HealthCare providers (i.e. Orthopedists, Neurologist, etc.) records will be provided as necessary. I also understand that my records and X-Rays may be released for payment purposes to Insurance Companies, Attorneys, and/or other third parties as necessary to obtain payment. By singing below I authorize the release of my records and X-Rays for these purposes. I understand that all my records will be kept confidential and will not be released without my written consent.

NOTICE OF PRIVACY PRACTICES

Gabbert Medical in accordance with HIPAA regulations wants to protect your rights and privacy as a patient. In addition, we will not provide your medical records to any outside third party for independent marketing purposes. All medical records are stored in compliance with Arizona State Law. Any questions regarding Privacy Practices may be directed to the Chief of Staff, Dr. Brian Gabbert who serves as the Privacy Officer. By signing below I acknowledge that I have been provided a copy of the ***Notice of Privacy Practices*** for Gabbert Medical (PP-09-23-13) and is available to me at any time upon request and in no way affects the care I receive at Gabbert Medical By signing below I authorize Gabbert Medicalto provide such care.

Patient Print Name: _____ **Date:** _____

Patient Signature: _____

Parent/Guardian Signature required if patient is under the age of 18.

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OFFICE POLICIES

OFFICE HOURS

Our office is open Monday-Thursday 9:00 am to 6:00 pm and Friday by appointment only. Patients are not scheduled from 12:00 pm through 2:30 pm during lunch. We are closed in observance of all major holidays.

NEW PATIENTS

For purposes of maintaining continuity of care, we ask that first time patients bring us the latest relevant records with the most recent test results, MRI / CT / XRAY/BLOOD WORK and current medications list. We do ask that you remain the sole custodian of your entire medical records from your previous healthcare providers. Should there be a need to further examine your previous records; our providers will have you bring your records back for additional review during subsequent office visits.

COURTESY

We strive to provide the best medical care for our patients. While we make every effort to provide prompt on-time service, the healthcare needs of each individual do not necessarily lend themselves to an exact schedule. We therefore appreciate your understanding and patience if you have to wait a few extra minutes. If you have any suggestions or complaints for our office, please let us know. Angry or foul language directed to our staff regardless of the issues involved will absolutely not be tolerated and will be grounds for immediate dismissal from our practice.

SUPERVISION OF CHILDREN & MINORS PRESENT WITHOUT PARENTS OR LEGAL GUARDIAN

Although we provide an area for children to entertain themselves, for safety reasons, we depend on parents to properly supervise their child(ren) at all times. Our staff cannot watch your children. Under no circumstances should a child under the age of 10 be left unattended. We also require a consent form signed by a parent or legal guardian to legally provide medical care to minors 16 and 17 years of age when the parent or legal guardian cannot be present. Minors 15 years of age or younger must be accompanied by a parent or legal guardian.

CHANGES IN ADDRESS, BILLING, OR CONTACT INFORMATION

Please notify our office in writing of any changes of address, telephone, billing or contact information. It is imperative that we have the most current information on file.

FEES & PAYMENTS

Prices/Fees are subject to change. Payment in full is due at the time services are rendered. We do not except any forms of insurance. We accept credit/ debit cards, cash, personal check, cashier's checks, HSA cards. A copy of your driver's license or photo ID will be taken for your file on record. Should you require a payment plan, our office manager will be glad to discuss your options with you.

Balances over 120 DAYS due may be sent to a collection agency unless other arrangements have been made. A $50 fee may be assessed on accounts placed in collections. We may also elect to discharge you from our practice should you fail to comply with our policy.

APPOINTMENTS AND NO SHOW

We make every effort to provide prompt medical care to all of our patients. If you are unable to keep a scheduled appointment, please let us know at least 24 hours in advance. A NO SHOW is when a patient fails to keep a scheduled appointment and does not give an appropriate amount of notice time. If you are scheduled for IV and or Injection therapy and no show, a fee may be assessed to cover the cost of wasted product if the IV or injection was pre-made. Fees will be assessed as follows, IV-$100.00 / Injection-$20.00 In the event that you have a special circumstance regarding your missed appointment, please contact our office manager. We understand that there may be issues beyond your control and want to be understanding of special circumstances.
If you are delayed and cannot make an appointment on time, please call to advise us of your situation and provide an estimated time of arrival. Any significant delay may require the visit to be rescheduled.
Should you have more medical issues that need to be addressed, please inform our staff when calling for appointments, and we will schedule more time for you accordingly. Multiple family member appointments must be scheduled in advance. Family members who are present at the time of another member's appointment, but are not scheduled, may be required to schedule an appointment at a later time.

TELEPHONE MESSAGES & PROCESSING OF REFERRALS

We will try our best to respond to your messages as soon as possible. However, please be aware that messages may take up to 24 HOURS to process and respond. More often than not, if your questions require extensive attention, the doctor may elect to have you make an appointment and come for further evaluation for quality assurance purposes.

MEDICAL RECORDS & FORMS

All requests for medical records must be on a HIPPA approved form, which must be properly and completely filled out and signed by the patient or legal guardian. Improperly filled out forms may delay your request. Please allow at least 10 BUSINESS DAYS for processing.
Medical records released to a new provider, specialist or school: For continuity of care and as a courtesy to the patient, our office will forward records requested at no charge.
Medical records released to the patient, some insurance companies, law firm or miscellaneous requests: Records are subject to copying fees.

IN A LIFE THREATENING SITUATION, PLEASE CALL 911 IMMEDIATELY.

Our friendly staff is committed to making your visit as pleasant as possible. Your comments or concerns are important to us. We rely on them to continue to improve our quality medical care to you and your family.

By signing below, I understand and agree to the office policies and procedures explained above. A copy of the office policies and procedures along with notice of privacy information regarding Gabbert Medical will be available to me upon request.

Patient Print Name: _____ **Date:** _____

Patient Signature: _____

Parent/Guardian Signature required if patient is under the age of 18.

FOR PATIENTS OVER 65 YEARS OF AGE (Please Read and Sign)

Gabbert Medical Medicare Policy

This agreement is between Dr. Brian Gabbert ("Physician"), whose principal place of business is 120 E. Main Street, Suite B, Payson AZ 85541, and [patient] _____ who is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. Patient is aware that the Physician has opted out of the Medicare program effective on 04/01/2017 for a period of at least two years, and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Physician agrees to provide the following medical services to Patient (the "Services"): Chiropractic Intake, Exam, Report of Findings, Physio Modalities, and Chiropractic Manipulation. In exchange for the Services, the Patient agrees to make payments to Physician pursuant to the Attached Fee Schedule.

Patient also agrees, understands and expressly acknowledges the following:

- Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he/she has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
- Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient acknowledges that a copy of this contract has been made available to him/her.
- Patient agrees to reimburse Physician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or his beneficiaries.

Today's [date] _____ by [Patient name] _____

[Patient signature] _____

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