NOVI HEALTH+ WELLNESS

New Patient Demographic Information Form

Patient Information

- **Full Name:** _____
- **Preferred Name (if different):** _____
- **Date of Birth:** _____
- **Gender:** ☐ Male ☐ Female ☐ Other: _____
- **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Contact Information

- **Address:** _____
- **City:** _____ **State:** _____ **ZIP Code:** _____
- **Primary Phone:** _____ ☐ Home ☐ Mobile ☐ Work
- **Secondary Phone:** _____ ☐ Home ☐ Mobile ☐ Work
- **Email Address:** _____

Employment Information

- **Occupation:** _____
- **Employer Name:** _____
- **Employer Address:** _____
- **Work Phone:** _____

Insurance Information

- **Do you have health insurance?** ☐ Yes ☐ No
- **Primary Insurance Company:** _____
- **Policy Holder's Name:** _____
- **Policy Holder's DOB:** _____
- **Policy Number:** _____ Group Number: _____
- **Secondary Insurance Company (if applicable):** _____
- **Policy Holder's Name:** _____
- **Policy Holder's DOB:** _____
- **Policy Number:** _____ Group Number: _____

NOVI HEALTH + WELLNESS

Privacy Policy

Information We Collect

We may collect the following types of information:

1. **Personal Information**: Includes your name, address, phone number, email, date of birth, and emergency contact information.
2. **Medical Information**: Includes health history, treatment plans, diagnostic results, and notes from your visits.
3. **Insurance Information**: Includes policy numbers, insurance provider details, and billing information.

How We Use Your Information

Your information is used to:

- Provide high-quality chiropractic and wellness care
- Schedule and manage appointments
- Process billing and insurance claims
- Communicate with you about your care and our services
- Comply with legal and regulatory requirements

How We Protect Your Information

We implement a variety of security measures to maintain the safety and confidentiality of your personal and medical information. These include:

- Secure electronic health record systems
- Restricted access to authorized personnel only
- Regular staff training on privacy practices

Sharing Your Information

We may share your information in the following circumstances:

1. **With Your Consent**: For referrals, coordinating care, or at your request.
2. **With Insurance Companies**: For billing and claim processing purposes.
3. **When Required by Law**: To comply with subpoenas, court orders, or other legal obligations.

Your Rights

As a patient, you have the following rights:

- Access to your medical records upon request
- Request corrections to inaccurate or incomplete information
- Restrict certain uses or disclosures of your information
- File a complaint if you believe your privacy rights have been violated

Patient Acknowledgment and Agreement: By signing below, I acknowledge that I have read and understand the Novi Health & Wellness Privacy Policy. I consent to the collection, use, and sharing of my information as described above. I understand that I may request a copy of this policy and can contact the office if I have any questions or concerns.

Patient Name: _____ **Signature:** _____**Date:** _____

Witness (Staff Member): _____ **Date:** _____

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Informed Consent Acknowledgment

Nature of Chiropractic Treatment

Chiropractic care focuses on the diagnosis and treatment of musculoskeletal and nervous system disorders through non-invasive techniques, including but not limited to:

- Spinal adjustments and manipulations
- Soft tissue therapies
- Physical modalities (e.g., heat, ice, electrical stimulation)
- Exercise and lifestyle counseling

The purpose of chiropractic treatment is to restore proper alignment and function, alleviate pain, and improve overall health and wellness.

Potential Benefits

Chiropractic care may provide the following benefits:

- Reduction of pain and discomfort
- Increased range of motion
- Improved joint and muscle function
- Enhanced overall well-being

Risks and Complications

While Chiropractic care is generally safe, there are potential risks, including but not limited to:

- Temporary soreness or stiffness
- Aggravation of existing conditions
- Rare but serious complications, such as injury to blood vessels or nerves

If you have any pre-existing medical conditions, please disclose them to your chiropractor to minimize risks.

You have the right to choose or refuse Chiropractic care and may consider other treatment options, including:

- Medical or surgical care
- Physical therapy
- Self-care or no treatment

Your chiropractor will discuss these alternatives if applicable to your condition.

Patient Responsibilities

To ensure the best outcomes, it is essential that you:

- Provide accurate and complete health information
- Follow the treatment plan as recommended
- Inform your chiropractor of any changes in your health or symptoms

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Acknowledgment and Consent

By signing this form, I acknowledge the following:

1. I have been informed of the nature of Chiropractic treatment, its potential benefits, risks, and alternatives.
2. I understand that no guarantees or assurances have been made regarding the outcome of my care.
3. I consent to receive Chiropractic care from Novi Health & Wellness and its providers.

I have had the opportunity to ask questions and have received answers to my satisfaction. I understand that I may withdraw my consent at any time by informing the office in writing.

Patient Name: _____ **Signature:** _____ **Date:** _____

Witness Signature: _____ **Date:** _____

NOVI HEALTH + WELLNESS

Authorization and Guarantee of Payments

General Payment Policies

1. **Insurance Billing**:
    - As a courtesy, Novi Health & Wellness will bill your insurance company on your behalf.
    - It is your responsibility to provide accurate and up-to-date insurance information.
    - Coverage verification is not a guarantee of payment. You are responsible for any amounts not covered by your insurance.
2. **Deductibles and Co-Pays**:
    - Any co-pays, coinsurance, or deductibles specified by your insurance policy are your responsibility and are due at the time of service.
3. **Out-of-Network Benefits**:
    - If Novi Health & Wellness is not in-network with your insurance, you are responsible for any additional costs not reimbursed by your plan.
4. **Non-Covered Services**:
    - You are responsible for payment of any services not covered by your insurance, including but not limited to certain Chiropractic treatments, massage therapy, or wellness products.
5. **Denials and Adjustments**:
    - If your insurance denies payment or adjusts claims for any reason, you are responsible for the remaining balance.
6. **Payment Methods**: We accept cash, checks, and major credit/debit cards. Returned checks will incur a $25 fee.

Authorization of Payments

By signing below, I:

- Authorize Novi Health & Wellness to submit claims to my insurance company on my behalf.
- Assign all insurance benefits directly to Novi Health & Wellness for services rendered.
- Understand that I am financially responsible for any remaining balance, including co-pays, deductibles, non-covered services, or denied claims.
- Agree to notify Novi Health & Wellness immediately of any changes to my insurance coverage.

Late Cancellation Policy

- We prefer that at least twenty-four (24) hours of advanced notice be given to cancel or change Chiropractic treatment appointments
- If Massage Therapy appointments are canceled less than twenty-four (24) hours prior to the appointment, or you miss your scheduled appointment, there will be a $30 late cancellation fee. This fee will be given in full to our massage therapist to ensure they are compensated for their reserved time and to acknowledge the effort they have made to prepare for your appointment.

Refund Policy

Refunds for prepayments or unused services will be processed upon written request. Discounted packages will return previously used treatments to revert to their original price, which may result in an additional balance according to our cash fees and pre-paid package pricing.

Acknowledgment and Agreement: I acknowledge that I have read and understand the payment policies of Novi Health & Wellness. I agree to these terms and accept full financial responsibility for all charges incurred.

Patient Name: _____ **Signature:** _____ **Date:** _____

Witness Signature: _____**Date:** _____

NOVI HEALTH + WELLNESS

Emergency Contact Form

Novi Health & Wellness

To ensure your safety and well-being during your care at Novi Health & Wellness, we request that you provide emergency contact information. This information will only be used in case of an emergency.

Patient Information

Name: _____

Date of Birth: _____

Primary Emergency Contact

Name: _____

Relationship to Patient: _____

Phone Number (Primary): _____

Phone Number (Secondary): _____

Email Address (Optional): _____

Secondary Emergency Contact (Optional)

Name: _____

Relationship to Patient: _____

Phone Number (Primary): _____

Phone Number (Secondary): _____

Email Address (Optional): _____

NOVI HEALTH + WELLNESS

Review of Systems (Check all that apply)

General:
☐ Fatigue ☐ Weight loss ☐ Weight gain ☐ Fever ☐ Other: _____
Musculoskeletal:
☐ Joint pain ☐ Stiffness ☐ Muscle weakness ☐ Neck/Back Pain ☐ Other: _____
Neurological:
☐ Headaches ☐ Dizziness ☐ Numbness ☐ Tingling ☐ Seizures ☐ Other: _____
Cardiovascular:
☐ Chest pain ☐ Irregular heartbeat ☐ Swelling in legs ☐ Other: _____
Respiratory:
☐ Shortness of breath ☐ Chronic cough ☐ Asthma ☐ Other: _____
Gastrointestinal:
☐ Nausea ☐ Vomiting ☐ Constipation ☐ Diarrhea ☐ Other: _____
Genitourinary:
☐ Frequent urination ☐ Painful urination ☐ Difficulty holding urination ☐ Difficulty starting urination
☐ Other: _____
Skin:
☐ Rash ☐ Itching ☐ Eczema ☐ Psoriasis ☐ Other: _____
Psychological:
☐ Anxiety ☐ Depression ☐ Mood swings ☐ PTSD ☐ Other: _____
Eyes/Ears/Nose/Throat:
☐ Vision changes ☐ Hearing loss ☐ Sinus issues ☐ Tinnitus ☐ Vertigo ☐ Other: _____
Endocrine:
☐ Heat/cold intolerance ☐ Excessive thirst ☐ Unexplained weight change ☐ Other: _____

Medical History

Current Medical Conditions:
☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Arthritis ☐ Cancer (Type): _____
☐ Other: _____ ☐ Other: _____ ☐ Other: _____

Past Surgeries/Procedures:
☐ Appendectomy ☐ Joint replacement ☐ Spinal surgery ☐ Other: _____

Hospitalizations:
Date: _____ Reason: _____ Date: _____ Reason: _____
Date: _____ Reason: _____ Date: _____ Reason: _____
Date: _____ Reason: _____ Date: _____ Reason: _____

Medications:
(Include prescription, over-the-counter, and supplements)

1._____ Dosage: _____ 2._____ Dosage: _____
3._____ Dosage: _____ 4._____ Dosage: _____
5._____ Dosage: _____ 6._____ Dosage: _____

Allergies (Medications, Foods, Environmental):
☐ None ☐ Yes, list: _____

Family Medical History:
☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Other: _____

Social History

Work:
☐ Full Time (30-40+ hours) ☐ Part Time (under 30 hours) ☐ Student ☐ Retired
Activity Level:
☐ Sedentary ☐ Moderate activity ☐ Active ☐ Very active
Exercise:
☐ None ☐ Occasional ☐ Regularly ☐ Daily
Tobacco Use:
☐ Never ☐ Former ☐ Current ☐ Amount: _____
Alcohol Use:
☐ Never ☐ Occasional ☐ Regular ☐ Amount: _____
Drug Use:
☐ Never ☐ Past ☐ Current ☐ Details: _____
Dietary Habits:
☐ Balanced ☐ High protein ☐ Low carb ☐ Other: _____
Sleep:
Hours per night: _____ Quality of sleep: ☐ Good ☐ Fair ☐ Poor
Stress Level:
☐ Low ☐ Moderate ☐ High

Signature & Date
I affirm that the information provided above is accurate and complete to the best of my knowledge.

Patient Print Name:_____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

NOVI HEALTH+ WELLNESS

Patient Intake

First Name:_____ Last Name:_____ Middle Initial:____ Date:_____

Date of Birth:_____ Age:_____ Gender: M / F Height:_____ Weight:_____ Occupation:_____

How did you hear about our office:_____ Is this an Auto or Personal Injury Case? (Specifiy)_____

Complaint Information

What problem(s) are you here for today?_____

When did this begin?_____ What caused this problem(s)?_____

Other complaint(s) (if acclipable):_____

On a scale of 1-10, how would you rate your complaint right now (1 being the best, 10 being the worst):_____

At its BEST:_____ At its WORST:_____ Have you experienced these symptoms before? (if so, when):

_____

How would you describe your symptoms? (ache/stiff/dull/sharp/numb/tingling/burning/other):_____

Do you get any traveling or shooting pain, numbness, or tingling? (if so, where):_____

What worsens your symptom(s)?_____

What decreases your symptom(s)? _____

Symptoms worsen with: ○ Coughing ○ Sneezing ○ Bearing Down ○ N/A

Symptoms are worse in the: ○ Morning ○ Afternoon ○ Evening ○ N/A

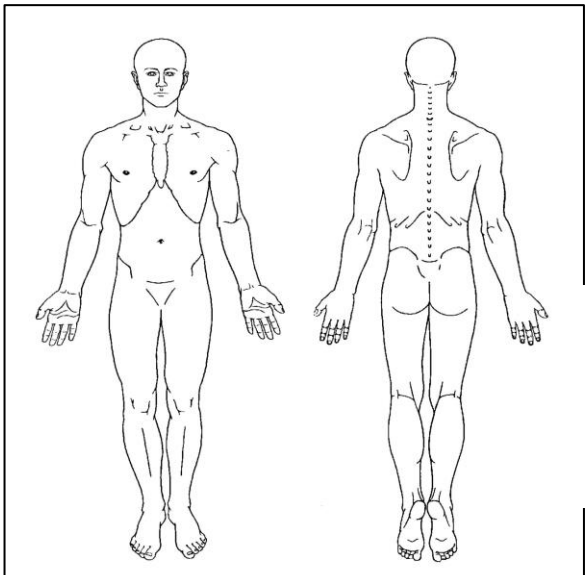
How often do you notice these symptom(s): ○ Constant ○ Frequent ○ Occasional ○ Intermittent ○ Comes and Goes

Do these symptom(s) interfere with sleep? ○ Yes ○ No If yes, how many nights out of the week? __ / 7

Have you seen another doctor or Chiropractor for these symptoms? ○ Yes ○ No (Dr. Name): _____

Have you had X-Rays or MRIs within the last year? ○ Yes ○ No Diagnosis/Treatment: _____

Please mark the areas below where these symptoms are located (include any radiating or traveling pain if applicable)



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