MARCO CHIROPRACTIC & MEDICAL REHAB CLINIC

239-394-7221
office@mcmrclinic.com
www.mcmrclinic.com
606 Bald Eagle Dr. #201
Marco Island, FL 34145

Welcome to Marco Chiropractic & Medical Rehab Clinic

Thank you for choosing Marco Chiropractic & Medical Rehab Clinic (MCMR) and for trusting us with your chiropractic and rehabilitative care. We are honored to be a part of your health journey and look forward to supporting you every step of the way.

To help streamline your visit, these intake forms are fully fillable. You may complete each section by clicking into the fields and using the Tab key on your keyboard to easily move from one question to the next. Once completed, please print the forms, and bring them with you to your appointment.

We understand that paperwork can sometimes feel frustrating. However, this information allows our team to better understand your needs and provide the highest level of personalized care. We truly appreciate your patience, time, and willingness to complete these forms in advance.

If you have any questions or need assistance, our team is always happy to help. We look forward to seeing you soon.

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Today's Date_____

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Chiropractic Intake Form

Patient Name_____ Date of Birth_____

Sex ◯ Male ◯ Female ◯ Other_____

Street Address_____

City_____ State_____ Zip Code_____

Mobile Phone_____ Email_____

Preferred Method of Contact ◯ Phone ◯ Email ◯ Text Message

Marital Status ◯ Married ◯ Single ◯ Divorced ◯ Widowed # of Children_____

Spouse Name_____ Phone Number_____

Employer (if any)_____ Job Title_____

Primary Physician_____ Phone Number_____

Emergency Contact_____ Phone Number_____

Relationship to Patient_____

Insurance Information

Primary Insurance_____

ID #_____ Group #_____ Effective Date_____

Secondary Insurance_____

ID #_____ Group #_____ Effective Date_____

Are you interested in reducing cellulite, fine lines, and wrinkles and increasing the overall appearance of your skin?, i.e. Endermologie ◯ Yes ◯ No

Are you interested in NerveOTX-direct current neurotherapy for pre-post surgery or to decrease recovery time, repair muscles/tendons/nerves? ◯ Yes ◯ No

Do you have Neuropathy and did you know there are options available to help? ◯ Yes ◯ No

Are you interested in Occupational Therapy or fascial stretch services? ◯ Yes ◯ No

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Patient Name_____

Chief Complaint

What brings you in the office today?_____

When did it begin?_____

Does it interfere with ◯ Work ◯ Sleep ◯ Daily Routine ◯ Recreation ◯ Other

Please explain_____

_____

How are your symptoms changing? ◯ Getting Better ◯ No Change ◯ Getting Worse

Are you currently or have you been treated for this condition before? ◯ Yes ◯ No

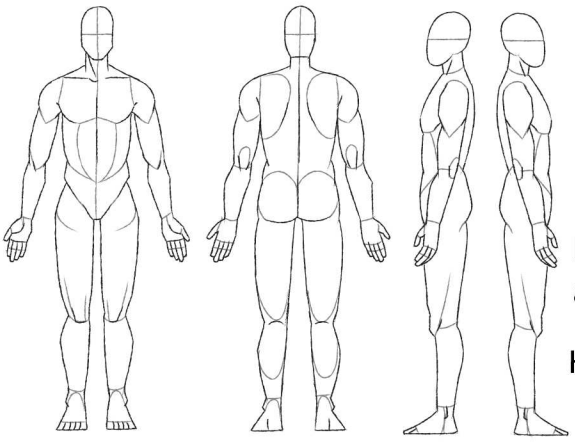
Type of treatment_____

Is your condition due to an accident? ◯ Yes ◯ No Date of Accident_____

Type of accident ◯ Auto ◯ Work ◯ Home Other _____

To who have you reported your accident? ◯ Auto Insurance ◯ Employer ◯ Workers Comp

Attorney name (if applicable)_____



Once you print the forms, circle the location(s) of your pain

Please indicate on a scale of 1-10 your pain level (1 = No Pain and 10 = the worst possible pain _____

Have you had these sympyoms previously? ◯ Yes ◯ No

If yes, how long ago?_____

How often do you experience your symptoms?

◯ Constantly (76-100%) ◯ Frequently (51-75%) ◯ Occasionally (26-50%) ◯ Intermittently (0-25%)

Have you had testing for this condition? ◯ XRays ◯ MRI ◯ CT Scan ◯ Other_____

Date and Location of testing_____

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Patient Name_____

Patient Health Information

Indicate the medical conditions you have had

◯ Arthritis ◯ Cancer ◯ Diabetes ◯ Heart Disease ◯ Hypertension
◯ Psychiatric Illness ◯ Skin Disorder ◯ Stroke ◯ Other_____

Indicate the surgeries you have had

◯ Appendectomy ◯ Brain ◯ Cardiovascular ◯ Carpal Tunnel ◯ Cervical Spine
◯ Gallbladder ◯ Gastrointestinal ◯ Hernia ◯ Hysterectomy ◯ Joint Replacement
◯ Knee ◯ Lumbar Spine ◯ Prostate ◯ Shoulder ◯ Thoracic Spine ◯ Urogenital
◯ Other_____

Indicate the allergies you have

◯ Eggs ◯ Fish/Shellfish ◯ Milk/Lactose ◯ Peanuts ◯ Soy ◯ Wheat/Gluten
◯ Other_____

Do you drink alcohol? ◯ Yes ◯ No **If yes, how many drinks per week?**_____
Do you smoke cigarettes? ◯ Yes ◯ No **If yes, how many cigarettes per day?**_____
Do you chew tobacco? ◯ Yes ◯ No **If yes, how often?**_____
Do you drink caffeine? ◯ Yes ◯ No **If yes, how many cups per day?**_____
How often do you exercise? ◯ Frequently ◯ Occasionally ◯ Rarely ◯ Never

List any prescription medicines and/or nutritional supplements you currently take

List any notable family medical history

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Patient Name_____

MCMR Clinic (Marco Chiropractic & Medical Rehab Clinic) MULTI-MODALITY INFORMED CONSENT FOR CARE

Thereby request and consent to the performance of diagnostic tests, clinical procedures, and various therapeutic treatments provided by the practitioners at MCMR Clinic (Marco Chiropractic & Medical Rehab Clinic). I understand that my care may be performed by or under the supervision of a Licensed Doctor of Chiropractic, Licensed Massage Therapist, Licensed Occupational Therapist, or other certified clinical staff.

1. SCOPE OF TREATMENT

I understand that treatment at this clinic may include, but is not limited to:

- **Chiropractic Care: Spinal and extremity adjustments/manipulations.**
- **Soft Tissue & Manual Therapy: Fascial Stretch Therapy (FST), massage therapy, and instrument-assisted soft tissue mobilization (IASTM).**
- **Physical Rehabilitation: Corrective exercises and functional movement protocols.**
- **Advanced Technology: Endermologie (LPG), electric stimulation, ultra sound, direct current neurotherapy or heat-based physiotherapy.**

2. MATERIAL RISKS OF TREATMENT

While the procedures performed here are considered among the safest in healthcare, I acknowledge that any clinical intervention carries inherent risks. These include, but are not limited to:

- **Common Reactions: Temporary soreness, stiffness, bruising (common with lASTM or deep tissue work), or a temporary increase in symptoms.**
- **Rare Reactions: Dizziness, nausea, flushing, or skin irritation/redness from topical products or Endermologie.**
- **Physical Strain: Aggravation of disc conditions or muscle strains during rehab or stretching.**
- **Fractures: In patients with underlying bone-weakening conditions (e.g., osteoporosis). I agree to notify my provider if I have any history of bone density loss.**

3. PATIENT RESPONSIBILITY & ACKNOWLEDGMENT

- **Disclosure: I have disclosed my full medical history, including any known pregnancies, implants, surgeries, or medications (specifically blood thinners).**
- **No Guarantees: I understand that the practice of healthcare is not an exact science. I acknowledge that no guarantee or assurance has been made regarding the results of my care.**
- **Right to Refuse: I understand I have the right to discuss the risks, benefits, and alternatives of any specific treatment and may withdraw consent at any time.**

At MCMR Clinic, our goal is to provide high-quality care in a timely manner. To ensure we can accommodate all patients, we require that you read and sign the following policies regarding payment and scheduling.

1. FINANCIAL RESPONSIBILITY

- Payment Due at Time of Service: Payment is required in full at the time services are rendered. This includes co-pays, deductibles, and self-pay fees for Chiropractic, FST, Massage, and Endermologie.
- Insurance: If we are billing insurance on your behalf, you are responsible for providing accurate and up-to-date information. You remain ultimately responsible for any balance not covered by your insurance provider.
- Packages and Memberships: All prepaid packages and memberships are non-refundable and non-transferable unless otherwise stated in a specific service agreement.

2. CANCELLATION & NO-SHOW POLICY

We value your time and ask that you respect ours. We reserve a specific time slot exclusively for you.

- 24-Hour Notice: We require at least 24 hours' notice for any appointment cancellation or rescheduling.
- Late Cancellation/No-Show Fee: Failure to provide 24 hours' notice, or missing your appointment entirely, will result in a fee of $25 added to your account balance and will be due at the next service time or over the phone.
- Late Arrivals: If you arrive late, your session may be shortened to avoid interrupting the next scheduled patient. The full service fee will still apply.

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SIGNATURE & AUTHORIZATION

I have read, or have had read to me, this informed consent and financial responsibility. I have had the opportunity to ask questions and all my concerns have been addressed to my satisfaction. I voluntarily consent to the treatments deemed advisable by my provider(s).

Patient Name (Print):_____

Patient Signature:_____

Date:_____

CONSENT TO TREAT A MINOR (If Applicable)

I, _____, being the parent/legal guardian of the minor,_____, hereby authorize the providers at MCMR Clinic to evaluate and treat said minor as deemed clinically advisable.

Parent / Guardian Signature:_____

Date:_____

HIPAA Patient Consent Form

This practice is committed to maintaining the privacy of your protected health information (PHI) which includes information about your health condition and the care and treatment you receive from the practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also detalls your rights regarding your PHl. You have the right to review our Notice before signing this Consent and you are advised to do so. The privacy of PHI in patient files will be protected when the files are taken to and from the practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the practice authorized to remove the files from the practice's office.

The patient understands that the practice:

- Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHl.
- Is required to abide by the terms of this Privacy Notice.
- Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHl that it maintains.
- Will make any revised Privacy Notice available to you per your request.
- Will not retaliate against you for filing a complaint.
- May disclose your PHI for treatment, payment, emergency situations and/or health care operations.
- Gives the patient the right to revoke this Consent in writing at any time and all future disclosures that require the patient's prior written consent will then cease.

Patient Name (Print):_____

Patient Signature:_____

Date:_____