

Hagerstown Health & Chiropractic  
Brenna Bacon Ranieli, DC, LLC  
1329 Pennsylvania Avenue  
Hagerstown, MD 21742  
Ph: 301-791-7111 F: 301-791-7119

PATIENT INTAKE FORM

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_  
Last First Middle

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

EMAIL: \_\_\_\_\_

PREFERRED CONTACT PHONE #: \_\_\_\_\_ SECONDARY PHONE #: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ GENDER (Please circle): M / F SOCIAL SECURITY NO.: \_\_\_\_\_

IN CASE OF EMERGENCY CONTACT NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

YOUR OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_ PHONE: \_\_\_\_\_

MARITAL STATUS: M S W D NAME OF SPOUSE: \_\_\_\_\_ NUMBER OF CHILDREN: \_\_\_\_\_

NAME OF PARENT/GUARDIAN (if patient is a minor): \_\_\_\_\_

HOW DID YOU HEAR ABOUT OUR OFFICE? \_\_\_\_\_

HAVE YOU EVER HAD CHIROPRACTIC CARE BEFORE? \_\_\_\_\_ DOCTOR'S NAME: \_\_\_\_\_

PURPOSE OF THIS APPOINTMENT: \_\_\_\_\_

PAYMENT METHOD: (Please Circle) Self Pay Health Insurance Personal Injury Protection Workers Compensation

IS THIS CONDITION DUE TO: AUTO ACCIDENT \_\_\_\_\_ WORK INJURY \_\_\_\_\_ OTHER \_\_\_\_\_ DATE: \_\_\_\_\_

IF THIS IS A RESULT OF ONE OF THE ABOVE, DO YOU HAVE A LAWYER? \_\_\_\_\_ YES \_\_\_\_\_ NO

LAWYER'S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PRIMARY CARE DOCTOR: \_\_\_\_\_ DATE LAST SEEN/REASON: \_\_\_\_\_

X \_\_\_\_\_  
Patient Signature

Flip Over → → → → → → → → → → \

**HAGERSTOWN HEALTH & CHIROPRACTIC  
BRENNA BACON RANIELI, DC, LLC  
1329 PENNSYLVANIA AVENUE  
HAGERSTOWN, MD 21742  
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**CONSENT FOR TREATMENT:** THE UNDERSIGNED CONSENTS TO THE TREATMENT AND THE PROCEDURES, WHICH MAY BE PERFORMED, DURING THE RECOMMENDED CHIROPRACTIC CARE.

**RIGHT TO REFUSE TREATMENT:** THE UNDERSIGNED UNDERSTANDS THAT HE/SHE HAS THE RIGHT TO MAKE AN INFORMED REFUSAL OF ANY TREATMENT THAT MAY BE CONSIDERED DURING OUTPATIENT CARE.

**FINANCIAL RESPONSIBILITY:** THE UNDERSIGNED AGREES, WHETHER HE/SHE SIGNS AS PATIENT, THAT IN CONSIDERATION FOR THE SERVICES TO BE RENDERED TO THE PATIENT HE/SHE HEREBY INDIVIDUALLY OBLIGATES HIMSELF /HERSELF TO PAY THE ACCOUNT OF DR. RANIELI, IN ACCORDANCE WITH THE REGULAR RATES AND TERMS OF DR. RANIELI.

**RELEASE OF INFORMATION:** THE UNDERSIGNED DOES HEREBY AUTHORIZE DR. RANIELI TO RELEASE AND OBTAIN ANY AND ALL INFORMATION REGARDING THE PATIENTS MEDICAL HISTORY AND TREATMENT ADMINISTERED DURING OUTPATIENT TREATMENT, TO ANY PHYSICIAN OR HOSPITAL OR TO ANY INSURANCE COMPANY, EMPLOYER, LEGAL COUNSEL OR OTHER ORGANIZATION RESPONSIBLE FOR THE PAYMENT OF THE PATIENTS MEDICAL EXPENSES. IF THE PATIENT IS COVERED BY MEDICARE, THE UNDERSIGNED AUTHORIZES ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT THE PATIENT TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. THE UNDERSIGNED CONSENTS TO ALLOW MESSAGES TO BE LEFT ON THE PERSONAL PHONE NUMBERS PROVIDED BY THE PATIENT ON THE INTAKE FORM REGARDING FUTURE APPOINTMENTS.

**ASSIGNMENT OF INSURANCE BENEFITS:** THE UNDERSIGNED AUTHORIZES, WHERE HE/SHE AS AGENT OR AS PATIENT, DIRECT PAYMENT TO DR. RANIELI OF ANY INSURANCE BENEFITS OTHERWISE PAYABLE TO OR ON BEHALF OF THE UNDERSIGNED FOR CHIROPRACTIC SERVICES. IT IS THE UNDERSIGNED'S RESPONSIBILITY TO SUPPLY THE OFFICE WITH A REFERRAL IF REQUIRED BY HIS/HER INSURANCE AND IF NOT SUPPLIED THE UNDERSIGNED WILL BE RESPONSIBLE FOR PAYMENT. IT IS UNDERSTOOD BY THE UNDERSIGNED THAT HE/SHE IS FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY THIS ASSIGNMENT.

**WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:** THE UNDERSIGNED HAS REVIEWED A COPY OF DR. RANIELI'S NOTICE OF PRIVACY PRACTICES AND A COPY WAS PROVIDED TO ME IF I REQUESTED IT.

BY SIGNING THIS FORM, I ADMIT THAT THE CONTENTS OF THIS FORM HAVE BEEN FULLY EXPLAINED TO ME AND I DO UNDERSTAND THE CONTENTS OF THIS FORM.

**SIGNATURE (PATIENT, PARENT, or GUARDIAN)**  \_\_\_\_\_ **DATE** \_\_\_\_\_

**Print Name** \_\_\_\_\_ **Relationship (circle one):**    **Self**        **Parent**        **Guardian**

**Patients Date of Birth** \_\_\_\_\_