

CHIRO ON CALL

New Patient Intake & Policies

Mobile Clinical Suite · Sun City, AZ 85373 · By Appointment Only

Draft packet — practice and compliance review required before use. This packet is designed for a first appointment with CHIRO ON CALL. Do not send completed forms, medical records, or other health information through a public website form or ordinary email. Please follow the practice's instructions for secure return or bring completed forms to your scheduled appointment.

0.1 Before your appointment

CHIRO ON CALL provides care inside a fully equipped Mercedes-Benz mobile clinical suite. The suite meets patients at a planned, vehicle-accessible location; treatment does not occur inside a patient's home or workplace. Appointments are scheduled in and around **Sun City, Arizona 85373** and are available **by appointment only**.

Please bring a photo ID, your completed packet, a current medication list, and any records the practice has asked you to provide. For urgent or emergency concerns, call 911 or seek emergency care.

0.2 New patient information

Legal name

Preferred name

Date of birth

Pronouns, if you wish to share

Mobile phone

Email address

Preferred language

Emergency contact name and phone

Preferred communication method: ☐ Phone ☐ Text ☐ Email

0.3 Appointment location and accessibility

Requested appointment area or general location

Vehicle access, parking, gate, or accessibility notes

Please do not include detailed medical information in the location field. The practice will confirm whether the selected location is appropriate for the mobile suite before the appointment is finalized.

0.4 Health history and reason for visit

Primary reason for today's visit

When did the concern begin? What makes it better or worse?

Current medications, supplements, and allergies

Prior treatment, surgery, imaging, or care related to this concern

Primary care clinician and other clinicians involved in your care

0.4.1 Please check any that apply

- | | |
|--|---|
| ☒ Recent fall, accident, or injury | ☒ Blood thinner or anticoagulant medication |
| ☒ Osteoporosis or history of fracture | ☒ Cancer history or active treatment |
| ☒ Pregnant or possibly pregnant | ☒ Pacemaker, implanted device, or metal implant |
| ☒ Numbness, weakness, or changes in coordination | ☒ None of the above |

Important: Tell the clinician immediately about severe or worsening pain, new weakness, loss of bladder or bowel control, fever, chest pain, shortness of breath, or any other urgent symptom. This packet is not a substitute for emergency evaluation.

0.5 Consent to evaluation and care

I request evaluation by CHIRO ON CALL and understand that the clinician will discuss appropriate options, anticipated benefits, material risks, and reasonable alternatives before care is provided. I understand that I may ask questions, decline any recommended service, or stop care at any time. I authorize the practice to maintain this intake information as part of my clinical record.

Patient or authorized representative signature

Date

0.6 Self-pay and financial responsibility policy

CHIRO ON CALL is a **self-pay practice** and **does not accept insurance**. The current first mobile-suite visit fee is **\$385**. Follow-up visits are **typically \$250**. Fees for additional services, products, or services requiring different arrangements will be discussed before they are provided.

I understand and agree that:

- I am responsible for payment at the time of service unless the practice confirms another arrangement in writing.
- I may request an itemized receipt for my records. The practice does not bill insurance on my behalf.
- If I choose to submit a receipt to an insurer, health plan, or other payer, reimbursement is not guaranteed and remains my responsibility.
- Appointment availability, payment methods, rescheduling, and any cancellation terms will be confirmed by the practice before the visit is scheduled.

Patient or authorized representative signature

Date

0.7 Mobile clinical-suite policy

I understand that CHIRO ON CALL provides care inside the mobile clinical suite at an agreed, vehicle-accessible location. The clinician and staff do not provide treatment inside my home or workplace. I will provide accurate location and parking information, follow reasonable safety instructions for access to the suite, and notify the practice as soon as possible if my location or schedule changes.

Patient or authorized representative signature

Date

0.8 Privacy acknowledgement and communication preference

I acknowledge that CHIRO ON CALL will make its Notice of Privacy Practices available to me. I understand that the practice may use or disclose health information for treatment, payment, and healthcare operations as permitted by law. I may ask the practice about reasonable communication preferences and privacy-related questions.

Preferred confidential contact method and any restrictions

Patient or authorized representative signature

Date

0.9 Office use only

Appointment date and time

Clinician / staff initials

Forms received

Payment arrangement confirmed
