

# WELCOME

## Patient Information

## Insurance

Date \_\_\_\_\_

Patient \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Single  Married  Widowed  Separated  Divorced

Patient Social Security Number \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer Phone \_\_\_\_\_

Children's Name(s)/Age \_\_\_\_\_

E-Mail: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Have you ever received treatment by a Chiropractor before?  Yes  No

If yes, when and who? \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

May we send the doctor a report?  Yes  No

Insurance Company \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ SS# \_\_\_\_\_

**ASSIGNMENT AND RELEASE:**

I hereby direct any and all insurance carriers, attorneys, and individuals to directly pay Reynoldsburg Chiropractic Center for charges incurred by me. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_

## Phone Numbers

## HIPAA NOTICE

Home \_\_\_\_\_ Work \_\_\_\_\_ Ext \_\_\_\_\_

Cell Phone \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext \_\_\_\_\_

The patient understands and agrees to allow this chiropractic office to use their patient health information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your patient health information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your patient health information we encourage you to read the HIPAA notice that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records please inform our office.

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian's signature \_\_\_\_\_ Date \_\_\_\_\_

## Patient Condition

Reason for Visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching

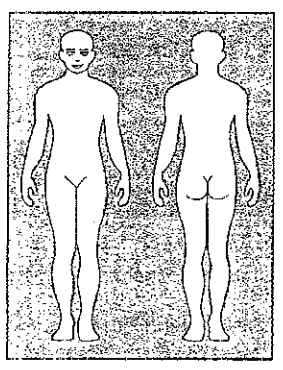
Shooting  Burning  Tingling  Cramps  Stiffness  Swelling  Other

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your  Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform  Sitting  Standing  Walking  Bending  Lying Down



# HEALTH HISTORY

What treatment have you already received for your condition?  Chiropractic Services  Medications  Surgery  
 Physical Therapy  None  Other \_\_\_\_\_

Name of other doctor(s) who have treated you for your condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Spinal Exam \_\_\_\_\_  
 MRI, CT-Scan, Bone Scan \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- |  |   |  |
|--|---|--|
| AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No            | High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No     |  |
| Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No          | Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No       |  |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No              | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No        |  |
| Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No           | Migraine Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No              | Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No         |  |
| Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No          | Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No            |  |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No              | Parkinson's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No | Pinched Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No        |  |
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No            | Prostate Problem <input type="checkbox"/> Yes <input type="checkbox"/> No     |  |
| Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No           | Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No           |  |
| Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No            | Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No     |  |
| Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No           | Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Gout <input type="checkbox"/> Yes <input type="checkbox"/> No                | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No               |  |
| Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No       | Suicide Attempt <input type="checkbox"/> Yes <input type="checkbox"/> No      |  |
| Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No           | Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No     |  |
| Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No              | Tumors, Growths <input type="checkbox"/> Yes <input type="checkbox"/> No      |  |
| Herniated Disk <input type="checkbox"/> Yes <input type="checkbox"/> No      | Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No               |  |
| High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |

OTHER: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<p><b>EXERCISE</b></p> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	<p><b>WORK ACTIVITY</b></p> <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	<p><b>HABITS</b></p> <input type="checkbox"/> Smoking _____ Packs/Day <input type="checkbox"/> Alcohol _____ Drinks/Week <input type="checkbox"/> Coffee/Caffeine Drinks _____ Cups/Day <input type="checkbox"/> High Stress Level _____ Reason _____
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Are you pregnant?  Yes  No Due Date \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone _____	_____	_____

(A) Notifier(s):

(B) Patient Name:

(C) Identification Number:

### ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

**NOTE:** If Medicare doesn't pay for (D) THERAPIES below, you may have to pay

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the (D) THERAPIES below.

(D) Goods/Services Medicare May Not Pay	(E) Reason Medicare May Not Pay	(F) Estimated Cost
ELECTRICAL STIMULATION AND ULTRASOUND	NOT COVERED	\$10 00
SPINAL DECOMPRESSION	NOT COVERED	\$20 00
REHAB	NOT COVERED	\$15 00 PER UNIT
EXAM X-RAY S AND CONSULTATION	NOT COVERED	\$100 00

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care
  - Ask us any questions that you may have after you finish reading
  - Choose an option below about whether to receive the (D) THERAPIES listed above
- Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this

(G) OPTIONS: Check only one box. We cannot choose a box for you.

**OPTION 1.** I want the (D) \_\_\_\_\_ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

**OPTION 2.** I want the (D) \_\_\_\_\_ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

**OPTION 3.** I don't want the (D) \_\_\_\_\_ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

**(H) Additional Information:**

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048)

Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature:	(J) Date:
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.