Joint Chiropractic Case History/Patient Information

Name:____________________________ Date:_____________

Social Security #_______________ Birth Date:__________ Race:______ Marital Status: M S W D

Address:_____________________________________City:___________________ State:______ Zip:___________

E-mail address:_____________________________

Cell:________________________ Home: ________________________ Work________________________

Occupation:__________________________ Employer:____

Employer's Address:___________________________________

Name of Emergency Contact:_______________________________________ Phone:__________________________

How were you referred to our office?____

When doctors work together it benefits you.

May we have your permission to update your medical doctor regarding your care at this office? Yes No

Family Medical Doctor_________________________________ Phone:____________________________________

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

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. ***The following person(s) have my permission to receive my personal health information***:

____

____

Patient/Guardian Signature:____ Date:________________

Name:____________________________ Date:_____________

HISTORY OF PRESENT AND PAST ILLNESS:

Reason for today's appointment:____

Date symptoms appeared or accident happened:____

Is this due to: Auto Accident______ Work______ Other____

Does anything make your symptoms improve? ____

Does anything make your symptoms worse? ____

Which of the following best describes your symptoms (circle all that apply):

Ache Burning Stabbing Spasm Numbness "Pins and Needles" Throbbing

Does your pain radiate? Yes No

PAIN SCALE: Please circle the number that best describes your overall pain:

0	1	2	3	4	5	6	7	8	9	10	10+
None		Little			Medium			Severe			Excruciating

Is there a particular time of day when pain is better? Yes No If yes, when:______________________________

Is there a particular time of day when pain is worse? Yes No If yes, when:______________________________

Have you ever had the same or a similar condition? Yes No

If the yes, when and describe: ____

Days lost from work (if applicable):_________________ Date of last physical examination:____________________

Do you have a history of stroke or hypertension?____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): ____

____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe:____

What medications or drugs are you taking?____

____

Do you have any allergies to any medications? Yes No

If yes, describe:____

Do you have any allergies of any kind? Yes No

If yes, describe:____

Do you have any Congenital Condition? Yes No
If yes, describe:____

Women: Are you pregnant? Yes No

Name:____________________________ Date:_____________

Have you had or do you now have any of the following symptoms/conditions?
Indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

Headaches______ Frequency	_________	Loss of Balance	___________
Neck Pain	_________	Fainting	___________
Stiff Neck	_________	Loss of Smell	___________
Sleeping Problems	_________	Loss of Taste	___________
Back Pain	_________	Unusual Bowel Patterns	___________
Nervousness	_________	Feet Cold	___________
Tension	_________	Hands Cold	___________
Irritability	_________	Arthritis	___________
Chest Pains/Tightness	_________	Muscle Spasms	___________
Dizziness	_________	Frequent Colds	___________
Shoulder/Neck/Arm Pain	_________	Fever	___________
Numbness in Fingers	_________	Sinus Problems	___________
Numbness in Toes	_________	Diabetes	___________
High Blood Pressure	_________	Indigestion Problems	___________
Difficulty Urinating	_________	Joint Pain/Swelling	___________
Weakness in Extremities	_________	Menstrual Difficulties	___________
Breathing Problems	_________	Weight Loss/Gain	___________
Fatigue	_________	Depression	___________
Lights Bother Eyes	_________	Loss of Memory	___________
Ears Ring	_________	Buzzing in Ears	___________
Broken Bones/Fractures	_________	Circulation Problems	___________
Rheumatoid Arthritis	_________	Seizures/Epilepsy	___________
Excessive Bleeding	_________	Low Blood Pressure	___________
Osteoarthritis	_________	Osteoporosis	___________
Pacemaker	_________	Heart Disease	___________
Stroke	_________	Cancer	___________
Ruptures	_________	Coughing Blood	___________
Eating Disorder	_________	Alcoholism	___________
Drug Addiction	_________	HIV Positive	___________
Gall Bladder Problems	_________	Ulcers	___________

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= “O” SOMETIMES= “S” NEVER= “N”

___________ Vigorous Exercise	___________ High Stress Activity
___________ Moderate Exercise	__________ Family Pressures
___________ Alcohol Use	__________ Financial Pressures
___________ Drug Use	__________ Other Mental Stresses
___________ Tobacco Use	__________ Other (explain)______
___________ Caffeine	______________________________

I certify the information provided is accurate to the best of my knowledge:

Name of Patient ____

Signature of Patient/Guardian ____ Date ____________________

Functional Rating Index

For use with neck and/or back problems. For each item below, please circle the number which most closely describes your condition right now.

Patient Name ____

1. Pain Intensity

0	1	2	3	4
0- No Pain	**1-** Mild Pain	**2-** Moderate Pain	**3-** Severe Pain	**4-** Worst Possible Pain

2. Sleeping

0	1	2	3	4
0- Perfect Sleep	**1-** Mildly Disturbed	**2-** Moderately Disturbed	**3-** Greatly Disturbed	**4-** Totally Disturbed Sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
0- No Pain No Restrictions	**1-** Mild Pain; No Restrictions	**2-** Moderate Pain; Go Slowly	**3-** Moderate Pain; Some Assistance	**4-** Severe Pain; 100% Assistance

4. Travel (driving, etc.)

0	1	2	3	4
0- No Pain on Long Trips	**1-** Mild Pain on Long Trips	**2-** Moderate Pain on Long Trips	**3-** Moderate Pain on Short Trips	**4-** Severe Pain on Short Trips

5. Work

0	1	2	3	4
0- Usual Work + Extra	**1-** Usual Work, No Extra	**2-** 50% of Usual Work	**3-** 25% of Usual Work	**4-** Cannot Work

6. Recreation

0	1	2	3	4
0- All Activities	**1-** Most Activities	**2-** Some Activities	**3-** Few Activities	**4-** No Activities

7. Frequency of Pain

0	1	2	3	4
0- No Pain	**1-** Occasional (25%)	**2-** Intermittent (50%)	**3-** Frequent (75%)	**4-** Constant (100%)

8. Lifting

0	1	2	3	4
0- No Pain with Heavy Weight	**1-** Increased Pain with Heavy Weight	**2-** Increased Pain with Moderate Weight	**3-** Increased Pain with Light Weight	**4-** Increased Pain with Any Weight

9. Walking

0	1	2	3	4
0- No Pain with Any Distance	**1-** Increased Pain after 1 Mile	**2-** Increased Pain after ½ Mile	**3-** Increased Pain after ¼ Mile	**4-** Increased Pain after Any Distance

10. Standing

0	1	2	3	4
0- No Pain with Any Time	**1-** Increased Pain after Several Hours	**2-** Increased Pain after 1 Hour	**3-** Increased Pain after ½ Hour	**4-** Increased Pain after Any Time

Patient or Guardian Signature ____ Date_______________

For Office Use:
Total __________ (/4, X10) = Functional Rating Score __________%

Joint Chiropractic Financial Policy

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we will suggest the chiropractic care we think will benefit you the most. We ask that you read and understand our policy, then choose the option that best applies to your particular situation. Unless prior arrangements have been made, payment is expected at the time services are rendered.

INSURANCE FORMS/PAYMENT

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers chiropractic care, although most policies do provide some level of coverage and the amount that is paid can vary from one policy to another. When possible, we will do everything we can to verify the benefits of your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, we will complete your claim forms and assist you in every way we can to collect payment. Please remember, however, that you are ultimately responsible for payment of any non-covered services, deductibles, or co-pays.

MEDICARE

We do accept assignment from Medicare. For chiropractors, Medicare will only cover manual manipulation of the spine depending upon the condition and if supported by x-ray and/or examination. You are responsible to pay any deductible and co-pay. All other services we provide are non-covered services. These services include but are not limited to x-rays, examinations, therapies, orthotics, supports, and nutritional supplements. You are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services.

TIME OF SERVICE DISCOUNT

Whether your insurance covers chiropractic services or not, our office offers a Time of Service (TOS) Discount to everyone. There is a savings of approximately 15% if you choose to pay for your services with this method of payment. In order to qualify for this discounted payment option, you must agree to the following:

1. All services are paid for THE SAME DAY they are provided (at the discounted rate).
2. You would submit the paperwork to your insurance company for the services provided at our office. We would not do this on your behalf. If needed, we will be happy to provide you with a statement of your charges for reimbursement.
3. Your insurance company will reimburse you at a later date for the services performed at our office.

ACKNOWLEDGEMENT

I have read the above and understand my options for payment of services rendered. I choose the following payment option for the services that I receive at Joint Chiropractic, LLC. (Please initial one)

Insurance/Medicare

_____ 1. I choose not to take the TOS discount. I understand that Joint Chiropractic, LLC will bill my insurance for me. I understand that I will be responsible for any outstanding amounts applicable after any insurance payments or balances have been applied.

Time of Service

_____ 2. I choose to take the TOS discount. I understand that I will pay for the services at the time they are rendered and I will be responsible for filing the claim with the insurance company in order to be reimbursed.

____ ___________________________

Signature Date

Revised 05/13 jda

INFORMED CONSENT

PATIENT NAME ______________________________

Clinic Name ***Joint Chiropractic***

Doctor's Name ***Dr Sarah Joint***

Address ***152 West 12th St, Erie, PA 16501***

Phone ***(814) 866-3366*** Fax ***(814) 866-8877***

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process..

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

____________________ DATE ____________________

Printed Name

____

Signature

____

Signature of Parent or Guardian (if a minor)

Joint Chiropractic Appointment and Cancellation Policy

Our goal is to provide the best quality chiropractic and nutrition care, and to do so in a timely manner. In order to accomplish this, we try not to overbook in order to ensure that we have sufficient time to adequately provide the care and attention needed to each of our clients.

We make every effort to accommodate your scheduling needs. We will also do our best to help remind you of your scheduled appointment time, but ultimately that responsibility is yours. In return we ask that you help us by keeping your scheduled appointments, arriving on time, and notifying us a minimum of 24 hours in advance if you will be unable to keep you appointment.

CANCELLATION OF AN APPOINTMENT

In order to take full advantage of your care program, we strongly recommend that you keep all appointments as scheduled. However, we understand that special circumstances can arise from time to time. If it is necessary to cancel your scheduled appointment, we ask that you notify our office at least 24 hours in advance.

To cancel your appointment, please call 814-866-3366. If you do not reach someone from the office, you may leave a detailed message on the answering machine. Calling as early as possible in the day is also greatly appreciated, as this will give us ample time to offer your appointment to another client who may be waiting to receive care.

LATE ARRIVALS

When we set up an appointment, a specific amount of time is reserved especially for you. If you are running late, please call our office to reschedule. On occasion we are able to work-in late arrivals into the schedule; however this is at the discretion of our front office staff. If you arrive more than 5 minutes late, we may ask you to reschedule in order to meet the needs of those who are on time for their pre-reserved visits. If this happens it will be considered a missed appointment.

MISSED APPOINTMENTS (*NO SHOWS*)

A "no show" is someone who misses an appointment without canceling it in an acceptable manner. When a client does not show up for their appointment, we lose the opportunity to see and help someone else. A missed appointment will be recorded in the patient's file. The first time there is a "no show," there will be no charge. Any additional "no-show" will result in a fee of $20.00 being billed to the patient's account with the appropriate provider. "No show" fees are the patient's responsibility and must be paid before your next appointment. The fee cannot be billed to your insurance company.

I have read and understand this policy. I agree to comply and realize that if I do not, I may be charged.

SIGNATURE_______________________________ DATE__________________