**Beachview Chiropractic Center**

## ABOUT YOU...

Name:_____ Age:_____ D.O.B:_____ Sex:_____

Home Address:_____ City/State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Marital Status:___ Spouse_____

Email Address:_____Social Security Number:_____

Preferred Language:_____ Race:_____ Are you Hispanic or Latino:_____

Employer:_____ Occupation:_____

Work Phone:_____Who told you about Beachview Chiropractic?_____

Name and No. of Emergency Contact:_____

Have you ever received Chiropractic care? **Y N** With whom?_____

Do you have a family medical doctor? **Y N** Who?_____Last Medical Exam:_____

**WOMEN:** Are you pregnant? **Y N** Date of last monthly period:_____

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## CURRENT HEALTH CONDITION

Current health complaints/reason for consulting our office:

1._____For how long?_____

2._____For how long?_____

3._____For how long?_____

In addition to the main reason for your visit today, what additional health goals do you have?_____

_____

Were other doctors seen for this condition? **Y N** Who?_____Results:_____

Has this condition occurred before? **Y N** Are the injuries of an accident? **Y N**

If yes, how did it occur?_____

Please list any medications/supplements currently taking (including dosage/frequency):_____

_____

Please list any allergies AND reactions to medications:_____

Please describe your daily activities for work, home, or school such as sitting, standing, lifting, phone usage:_____

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## PAST HEALTH HISTORY

Have you had an accident, even as a passenger, in a(n): **(give dates)**

Automobile:_____Motorcycle:_____Bicycle:_____Other:_____

Medical interventions: **(Circle all that apply)**

Hospitalizations PT Surgery Heart Appendix Hysterectomy Spinal Eye Organ Removal Other

Explain with dates:_____

Injuries: Have you ever had...**(circle all that apply)**

Broken Bones Spinal/Nerve Disorder Used a crutch/walker Used Neck/Back Bracing Been Unconscious

Sports Injuries

Explain with dates:_____

Do you consume: AlcoholCoffee/caffeine Water Intake If so how much:_____

Please Circle your smoking status: Everyday Some Days Former Never

Exercise: None Moderate Daily

**Have you ever had/have any of the following diseases? (circle all that apply)**

Heart Diabetes Cancer Thyroid Issues Lymes Tuberculosis Hepatitis Chicken Pox STD AIDS MS

**Circle any of the following conditions you have had in the past six months:**

**Musculo-skeletal**
Arthritis/RA/Gout
Low Back Pain
Neck/Arm Pain
Shoulder Pain
Joint Pain/Stiffness
Knee Pain
Walking Difficulties
Difficulty Chewing/TMJ
General Stiffness

**Nervous System**
Anxiety
Headaches/Migraines
Numbness/Tingling
Paralysis
Dizziness/Fainting
Forgetfulness
Confusion/Depression
Fibromyalgia
Convulsions

**Sensory**
Cataracts/Glaucoma
Sore Throat/Frequent Colds
Earaches/Hearing Trouble
Stuffy Nose/Congestion
Ringing In Ears

**Male/Female**
Menstrual Irregularity/Cramps
PMS
Vaginal Pain/Infections
Breast Pain/Lumps
Prostate Issues/ED
Sexual Dysfunction

**Digestive**
Heartburn/Acid Reflux
Diarrhea/Constipation
Ulcer
Frequent Nausea/Vomiting
Poor/Excessive Appetite
Excessive Thirst
Hemorrhoids
Liver/Gall Bladder Issues
Sudden Weight Change
Food Sensitivities
IBS/GERD/Colitis

**Cardiovascular/Respiratory**
Shortness of Breath
High Blood Pressure
High Cholesterol
Heart Problems
Irregular Heartbeat/ Pacemaker
Chest Pains
Varicose Veins/Poor Circulation
Ankle Swelling
Emphysema/Pneumonia

**Urinary**
Frequent Urination/Leakage
UTI
Kidney Stones

**Please outline the area(s) of your discomfort...**

**Quality of Symptoms** Please circle what it feels like

| | |
|---|---|
| Numbness | Burning |
| Tingling | Shooting |
| Stiffness | Throbbing |
| Aching | Sharp |

Signature_____ Date_____

**Changing the healthcare of our world!**

# Activities of Daily Living Questionnaire

When you experience difficulties from a painful or restrictive condition, you may find it difficult to do some of the things you normally do. In order to properly assess your condition, we must understand how much your problems have affected your ability to manage everyday activities.

For each item below, please rate how well you can do the following activities with the following:

**0= NO ISSUES 1=MILD 2=MODERATE 3= SEVERE**

| | | |
|---|---|---|
| _____Bending | _____Climbing Stairs | _____Lifting |
| _____Sitting | _____Standing | _____Walking 20 + minutes |
| _____Lying Down | _____Rising out of chair | _____Turning over in bed |
| _____Housework | _____Driving/riding | _____Dressing |
| _____Sleeping | _____Exercise | _____Yardwork |
| _____Golf | _____Cycling | _____Family activities |
| _____Work activities | _____Sleep Disturbances (less than 4 hours without interruption) | |

Chiropractic Goals:_____

_____

NAME_____ DATE_____

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# Basic Nutrition Questionnaire

Have you ever been told you have High Cholesterol or Triglycerides? YES / NO

Have you ever been diagnosed with High Blood Pressure? YES / NO

Have you been Diagnosed as Diabetic? YES / NO

Have you been diagnosed as Pre-Diabetic or Metabolic Syndrome? YES / NO

How many days a week do you skip a meal? (3/meals/day) _____

How many "fast food', "refined food", or "pre-prepared" meals to you eat per week?

(0) (1-3) (4-6) (7+)

How many servings of fruit do you eat per day?

(0-1) (2-3) (4-5)

How many servings of vegetables do you eat per day?

(0-1) (2-3) (4-5)

Do you regularly drink 1 or more per day of the following: (circle all that apply)

Soda Diet Soda Coffee Juice Milk Alcohol

How many servings of refined sugar do you eat per day? (Candy, Cookies, Cake, etc)

(0-1) (2-3) (4-5)

Please list all nutritional supplements/vitamins you take regularly:

(Staff can photocopy a list if you have one)

| Supplement Name/Type | Frequency | Brand or Where Purchased |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

# NOTICE OF HIPAA PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND REPORT ANY GRIEVANCE TO THE DLS PRIVACY OFFICIAL.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the Patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

We have prepared this "Summary Notice of HIPAA Privacy Practices" to explain how we are required to maintain the privacy of your health information and how we may use and disclose your health information. A Notice of HIPAA Privacy Practices containing a more complete description of the uses and disclosures of your health information is available to you upon request and publicly posted.

We may use and disclose your medical records for each of the following purposes: treatment, payment, and health care operations:

TREATMENT means providing, coordinating, or managing health care and related services by one or more health care providers.
PAYMENT means such activities as obtaining reimbursement for services, billing or collection activities and utilization review.
HEALTH CARE OPERATIONS include the business aspects of running our clinic, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide other health-related services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the DLS Privacy Officer:

1. You have the right to ask for restrictions on the ways we use and disclose your health information for treatment, payment and health care operations. You may also request that we limit our disclosures to persons assisting your care. We will consider your request, but are not required to accept it.
2. You have the right to request that you receive communications containing your protected health information from us by alternative means or at alternative locations. For example, you may ask that we only contact you at home or by mail.
3. Except under certain circumstances, you have the right to inspect and copy medical, billing and other records used to make decisions about you. If you ask for copies of this information, we may charge you a nominal fee for copying and mailing.
4. If you believe that information in your records is incorrect or incomplete, you have the right to ask us to correct the existing information or add missing information. Under certain circumstances, we may deny your request, such as when the information is accurate and complete.
5. You have a right to receive a list of certain instances when we have used or disclosed your medical information. We are not required to include in the list uses and disclosures for your treatment before April 14, 2003 among others. If you ask for this information from us more than once every twelve months, we may charge you a fee.

| | |
|---|---|
| Patient Name – Printed | Date |
| Patient Signature | Healing Hands Chiropractic Representative |
| Parent or Patient Representative Signature | Representatives Printed Name and Relationship to Patient |

*Revised January 1, 2010*

# AUTHORIZATION TO PERFORM X-RAYS

Date: _____

I authorize Dr. Rush to perform a radiographic examination, which is necessary to diagnose my present musculoskeletal problem (or illness).

Signed: _____

To the best of my knowledge, I am NOT pregnant and the above named doctor has permission to x-ray me for diagnostic interpretation.

Signed: _____

*X-rays are the property of Healing Hands Chiropractic and Functional Medicine. If copies are requested, a fee will incur.

# OFFICE FINANCIAL POLICY

1. First day services are to be paid in full unless arrangements have been made prior to services rendered.
2. All patients are on a cash basis unless other applicable coverage stated in section 1. of "Other Coverage" is applied.
3. All patients will be presented with a payment plan upon their third visit, where the financial obligations and insurance coverage will be explained in full.
4. We accept many forms of payment included but not limited to: cash, checks, VISA, MasterCard, Discover®.

## Other Coverage

1. We accept assignment for Blue Cross/Blue Shield.
2. We do not accept assignment for Workers Compensation, Personal Injury or any other Major Medical.
3. This office will supply you with a statement you can submit to your insurance company. Be aware we are not a mediator between you and your insurance company and will not enter into any dispute with them, as your contract is between you and them.
4. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the current bill for services rendered is due and payable in full immediately.
5. We file electronically for Medicare; however, you are responsible for payment to this office.
6. Due to Medicare regulations, discounts cannot be offered. Any promotional fee will go towards your initial visit.
7. **There will be a $25 cancellation fee for any appointments cancelled or rescheduled without 24 hours notice and a $50 no show fee.**
8. *If you have questions concerning this or any other matter, please speak with the Office Manager prior to seeing the doctor.*

Thank you.

I have read and understand the Financial Office Policy and agree to abide by these terms.

_____ _____

Patient's Signature Date

# ABOUT MEDICARE CHIROPRACTIC COVERAGE

Your Medicare coverage of chiropractic care is limited. They will only pay for the chiropractic adjustment (manipulative treatment) when it meets Medicare's rules. There are three categories of Medicare services: 1) non-covered 2) always-covered, and 3) perhaps-covered.

## NON-COVERED SERVICES

According to existing Medicare law, most of the available services in our office are NON-COVERED. Hopefully, the U.S. Congress will change that someday and treat Doctors of Chiropractic like all other doctors. Until then, here is a summary:

### Examples of Non-Covered Services

*All Services Other than Chiropractic Adjustments:*

- Office Visits - to evaluate and manage, re-evaluate, advise, or counsel.
- Physiotherapy - such as massage, traction, electrical stimulation, neuromuscular re-education, etc.
- X-rays, Laboratory, Supplies, Vitamins, etc.

*Various Chiropractic Adjustments:*

- Non-spinal manipulation to the shoulder, arm, leg, etc.
- Maintenance Care - you are stable and not making any more improvement.
- Wellness Care - to promote better health.

Non-covered items will appear on your insurance claim form. They will show as a Medicare Non-covered service like this: "72010–GY". The "72010" code is for an x-ray. The "-GY" means that it is not-covered, allowing your service to go through the Medicare system. After denial by Medicare, it can then go on to your other insurance. If you have Medigap Insurance (also known as Medicare Secondary or Supplemental insurance) they will pay according to the terms of your contract.

## ALWAYS-COVERED SERVICES

A typical example of a Medicare COVERED service is when you are injured or you are in much pain due to a bad spinal condition. You should expect Medicare to pay for your rehabilitation as long as you are improving. This phase of care is call "active treatment." It will be shown on your Medicare claim form and payment reports with your service code. For example, "98940-AT."

## PERHAPS-COVERED SERVICES

Your Chiropractic Adjustment must be clinically needed according to Medicare rules. If Medicare determines that your condition is not "Medically Necessary" they won't pay. If we know or believe that Medicare will not pay for your chiropractic adjustment, we will discuss this matter with you. We will also give you a special Medicare form known as the Advance Beneficiary Notice (ABN).

### MY FINANCIAL RESPONSIBILITY

I have received the above information, "About Medicare Chiropractic Coverage." I understand that I am personally financially responsible for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, copayments, or non-covered services as may be required by my insurance plan.

x _____ _____

Signature of patient or person acting on patient's behalf — Date

### MY AUTHORIZATION

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

x _____ _____

Signature of patient or person acting on patient's behalf — Date

*NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to a payer, your health information on this form may be shared with the payer. Your health information which the payer sees will be kept confidential by the payer.*

# CHIROPRACTIC INFORMED CONSENT

## CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy and Medicine. Chiropractic health care seeks to restore health through natural means without the use of drugs or surgery. This gives the body maximum opportunity to utilize its inherent healing powers. The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from Chiropractic.

## ANALYSIS

A Doctor of Chiropractic conducts clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation (VS). When such VS complexes are found, Chiropractic adjustments may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inborn healing powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon your body's healing mechanism.

## DIAGNOSIS

Doctors of Chiropractic do not offer to diagnose or treat any disease or conditions other then VS. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

## INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Doctor of Chiropractic, gives us the permission and authority to care for you in accordance with the chiropractic analysis. The chiropractic adjustment is usually beneficial and seldom causes any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment if we are aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from what would otherwise not come to the attention of the Doctor of Chiropractic. We provide a specialized, non-duplicating health service. We are licensed in a special practice and we are available to work with other types of providers in your health care regime.

## RESULTS

The purpose of Chiropractic services is to promote natural health through the reduction of the vertebral subluxations. Since there are so many variables, it is difficult to predict the time schedule or the efficacy of the chiropractic procedures. Sometimes the response is phenomenal. In most cases, there is a more gradual, but quite satisfactory response.

All questions regarding the doctor's objective pertaining to my care have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____

SIGNATURE DATE