Name: ______________________________ Date: __________

Address: ______________________ City: __________ State: ______ Zip: ________

Home Phone: ____________ Work Phone: _____________ Cell Phone: ________________

Date of Birth: ______________ Age: _____ Sex M F Email: __________________

Employed by: ______________________________ Occupation: __________________

Address: ______________________ City: ____________ State: ______ Zip: __________

Marital Status: ❑M ❑S ❑D ❑W Spouse's Name: ______________ Children? ❑Yes ❑No Ages: ________

In case of emergency, please notify: ______________________ Phone: __________________

Whom can we thank for referring you to our office?__________________ ❑ Citysearch ❑ yelp ❑ facebook

❑ YELLOWPAGES.COM ❑Mailing ❑Ins.Co. web Site ❑ The web, ***what site***?__________________❑Other______________

If you are accepted for care, who is responsible for your bill? ❑Self ❑Spouse ❑Parent

❑Workers Comp ❑Auto accident / no-fault insurance ❑Personal injury ❑Medicare

❑Health Insurance Co. Name ______________________ ❑Other ______________________

Why This Form Is Important:

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual; not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Your Early Years: (birth to 17yrs)

Current research has shown that many of the health challenges that occur in our adult life have their beginnings during our childhood years, some starting as early as birth.

	Yes	No	Unsure
Did you have any serious falls as a child?	❑	❑	❑
Were you involved in any car accidents as a child?	❑	❑	❑
Were you active in youth sports?	❑	❑	❑
Did you wear braces?	❑	❑	❑

Date of most resent auto accident / bad fall or injury

	Yes	No	Unsure
Were you vaccinated?	❑	❑	❑
As a child, did you receive regular chiropractic care?	❑	❑	❑
Did you have any surgery as a child?	❑	❑	❑
Did you use any medications (antibiotics, inhalers, aspirin, etc.) on an on-going basis?	❑	❑	❑

Adult Years: (18+yrs)

	Yes	No
Did/ do you smoke?	❑	❑
Did/ do you drink alcohol?	❑	❑
Have you been in any accidents?	❑	❑
Have you had any surgery?	❑	❑

	Yes	No
Did/ do you play any adult sports?	❑	❑
Did/ do you participate in any extreme sports?	❑	❑
On a scale from 1-10 describe your stress level. (1=none/ 10 Extreme)	❑	❑

Occupational 1 2 3 4 5 6 7 8 9 10
Personal 1 2 3 4 5 6 7 8 9 10

Do you?	**Yes**	**No**
Floss daily:	❑	❑
Belong to health club:	❑	❑
Take vitamins:	❑	❑
Drink bottled water:	❑	❑

Describe your:

Diet	*Excellent*	*Good*	*Poor*
Exercise	*Excellent*	*Good*	*Poor*
Sleep	*Excellent*	*Good*	*Poor*
Health	*Excellent*	*Good*	*Poor*

Reasons for consulting office:

Please briefly describe the *chief area of complaint* ***If you have no symptoms or complaints and are interested in Wellness services, please let us know.*

.

Intensity Scale-1=low; 10=unbearable

1.______________________________When did it start________ ***1 2 3 4 5 6 7 8 9 10***

2.______________________________When did it start ________ ***1 2 3 4 5 6 7 8 9 10***

3.______________________________When did it start________ ***1 2 3 4 5 6 7 8 9 10***

How often is the pain present? ❑Intermittent (25% or less) ❑Occasional (26-50%) ❑Frequent (51-80%) ❑Constant (81-100%)

Since your problem began, is your pain? ❑Getting better ❑Staying the same ❑Getting worse

How did your problem begin? ❑Auto accident ❑Work related ❑Other type of accident ❑Gradual Onset

❑Sudden Onset ❑No Specific reason Please explain:______________________________

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(Over)

What makes it worse? Please check all that apply:

❑Walking ❑Standing ❑Sitting ❑Stairs ❑Driving ❑Working ❑Moving/Exercise ❑Sneezing/Coughing ❑Other:___________

Medications currently taking (OTC/Prescription)*:*____

Were you treated for this condition previously? ❑Yes ❑No If yes, by whom? ❑Chiropractor ❑MD ❑Physical Therapist

❑ Other ____________________List dates, types of treatments and results: ______________________________

Does your problem affect your ability to work or affect your routine daily activities? ❑No effect ❑Limited restrictions but can function ❑Needs some assistance with daily activities ❑Cannot work ❑Cannot function without assistance ❑Totally disabled

List all Surgeries, Hospitalizations, Infections, Traumas: ______________________________________

Previous Chiropractor: ❑ Yes ❑ No Dr.______________________Time under care_______ Last Visit______________________

Reason for interrupting care:____

Other Doctors seen for this problem: ❑MD/specialist__________ ❑Physical Therapist ❑ Other ___________________________

List dates, types of treatments and results: ____

Primary Care Physician ____________________________date last seen __________reason for visit _____________________________

Check off any of the following symptoms you have ever had even if you think they are not related to your problem:

MUSCULO-SKELETAL
❒Neck Pain
❒Arm Pain
❒Shoulder Pain
❒Hand/Wrist Pain
❒Mid Back pain
❒Low Back Pain
❒Upper Leg/Hip Pain
❒Lower Leg/Hip Pain
❒Ankle/Foot Pain
❒Walking Problems
❒Joint Pain/Stiffness/Swelling
❒Arthritis
❒Jaw Pain/TMJ
❒Scoliosis

NERVOUS SYSTEM
❒Nervous
❒Numbness
❒Paralysis
❒Dizziness
❒Forgetfulness
❒Confusion/Depression
❒Fainting
❒Convulsions
❒Cold/Tingling limbs
❒High stress

GENERAL
❒Fatigue
❒Allergies
❒Fever
❒Headaches
❒Diabetes
❒Cancer
❒Skin Conditions

GASTRO-INTESTINAL
❒Poor/Excessive Appetite
❒Excessive Thirst
❒Frequent Nausea
❒Vomiting
❒Diarrhea
❒Hemorrhoids
❒Liver Problems
❒Gall Bladder Problems
❒Weight Trouble (Loss/Gain)
❒Abdominal Cramps
❒Gas/Bloating After Meals
❒Heartburn
❒Colitis
❒Digestive Problems

GENITO-URINARY
❒Bladder/Kidney Trouble
❒Painful/Excessive Urination
❒Discolored Urine

C-V-R
❒Chest Pain
❒Short Breath
❒Blood Pressure Problem
❒Irregular Heartbeat
❒Heart Disease
❒Lung Congestion
❒Respiratory Condition
❒Varicose Veins
❒Ankle Swelling
❒Stroke

EENT
❒Vision Problems
❒Dental Problems
❒Sore Throat
❒Earaches
❒Hearing Difficulty
❒Stuffed Nose

▶ ***FEMALES ONLY:*** **ARE YOU PREGNANT? Yes /months__________ No** When was your last period? ____________

❒Menstrual Irregularity ❒Menstrual Cramps ❒Vaginal Pain/Infection ❒Breast Pain/Lumps

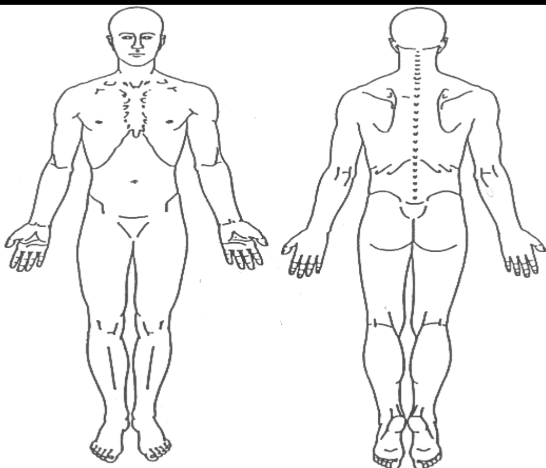
Family Health Profile: *At our office we are not only interested in your health and well-being, but also the health and well-bing of your family and loved ones. Please mention below any health conditions or concerns you may have about your:*

❒ Mother __________________ ❒ Sister ___________________ ❒ Brother___________________
❒ Father __________________ ❒ Spouse __________________ ❒ Child ___________________

Please fill in diagram below

Using the letters below please mark on these figures the area and type of altered sensation you are experiencing.

P = Pain **T** = Tingling **S** = Stiffness
B = Burning **N** = Numbness **M** = Muscle Spasm



Patient signature __________________**date**_______

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DOCTOR'S NOTES:

____
____
____
____
____
____
____
____

Recommendations: ❒X-rays ❒Ice/heat ❒EMG ❒MRI

____

Patient Accepted: ❒ YES ❒ NO ❒ Referred
Doctor's Signature: _______________________Date______
I have reviewed the information contained on this form with the patient

Chiropractic Office

INFORMED CONSENT TO RECEIVE CHIROPRACTIC CARE

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to correct vertebral and extremity subluxations. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked,” and you may feel movement of the joint. Various professionally accepted ancillary procedures, such as hot or cold packs, therapeutic exercise, neuro-muscular re-education, manual therapy, therapeutic massage or traction may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic adjustment. Complications could include muscle strain, ligament sprain, dislocation of joints, bone fracture, or injury to intervertebral discs, nerves or spinal cord. In extremely rare cases, cerebrovascular injury, or stroke, could occur upon severe injuries to the arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of care. The ancillary procedures could produce minor complications.

Probability of risks occurring: The risk of complications due to chiropractic treatment have been described as “rare,” about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury, or stroke, has been estimated at one in one million to one in ten million. The probability of adverse reaction due to ancillary procedures is also considered “rare.”

Other treatment options in lieu of Chiropractic Care that could be considered may include the following:

- ***Over the counter analgesics.*** The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- ***Medical care*,** typically anti-inflammatory drugs, tranquilizers and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- ***Hospitalization*** in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- ***Surgery*** in conjunction with medical care will complicate the condition and make future correction and rehabilitation more difficult.

I have read the explanation above of chiropractic care. I have fully evaluated the risks and benefits of undergoing chiropractic treatment. I have had the opportunity to have all my questions answered to my satisfaction. I have freely decided and choose to undergo the recommended chiropractic care, and hereby give my full consent to care and treatment.

________________________	_____________________________	_______________
Printed Name	Signature	Date

Chiropractic Office

TERMS OF ACCEPTANCE

At The New York Chiropractic Life Center, when a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal, and that is to eliminate vertebral subluxations. On a daily basis, we experience physical, chemical and emotional stresses that often accumulate and result in these vertebral subluxations, which in turn can cause a serious loss of health and well-being. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses resulting in a lessoning of the body's innate ability to express its maximum health potential. Often times, the effects of these vertebral subluxations are gradual in nature and can remain undetected until they become severe. Symptoms are usually the last things to show up in the disease process and the first to disappear as the correction begins

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine, by hand or mechanical means.

Health: A state of optimal physical, mental and social well being, not merely the absence of infirmity.

We do not offer to diagnose or treat any disease. We only offer to diagnose vertebral subluxations and associated conditions. 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 another health care provider that specializes in that area.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

CARE CHOICES: Patients come to our office for a variety of reasons.

Crisis/Relief Care: symptomatic pain relief (patch-up care). It corrects the most recent layer of spinal or neurological damage.

Reconstructive/Corrective Care: cause of problem corrected as well as symptomatic relief (fix-up care). Concerned with corrected years of damage that occurred when there were few symptoms

Wellness/Maintenance Care: for relief and spinal correction in addition to looking forward to maintaining heightened state of wellness and vitality.

Please choose type of care that best fits your health and life style goals.

❑ Relief care ❑ Corrective Care ❑ Wellness care ❑ I would like the doctor to select the appropriate care _____ *(initial)*

I understand that no guarantee of assurance will be made or has been made to the results that may be obtained. I further understand that if my care requires x-rays to be taken, the fee paid for this service is for analysis only. The actual films are the property of The New York Chiropractic Life Center. Once films are used for the purposes of care, they cannot be released. Copies may be made if necessary, at a nominal fee.

I clearly understand and agree that all fees for services rendered to me are ultimately my responsibility.

I, ____________________________________, have read and fully understand the above statements.
(please print your name). ***Initial and Date*** _________/_______

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

____ ________________________
(signature) (date)

Pregnancy Release:

This is to certify that, to the best of my knowledge, I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period: _____________________ ***Initial and Date*** _________/_______

Consent to evaluate and adjust a minor / child

I, ____________________________________, being the parent or legal guardian of _________________________________ have fully read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

____ ________________________
(signature) (date)

Chiropractic Office

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at The New York Chiropractic Life Center, we may use or disclose personal and health related information about you in the following ways:

*Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment. *Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer (if they are or may responsible for the payment of your services.) *Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care. Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

*If we are providing health care services to you based on the orders of another health care provider. *If we provide health care services to you in an emergency. *If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so. *If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care. *If we are ordered by the courts or another appropriate agency

Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences. You have the right to inspect and/or copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing. We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as change in our privacy notice will apply for all of your health information in our files Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the Information and may no longer be protected by the federal privacy rules. If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: New York State Insurance Dept.

If you would like further information about our privacy policies and practices please contact: Dr. Handt, DC

Patient Authorization for appointment reminders, Sign in sheets and scheduling related matters

It is our desire for our staff to use your name, address and/or telephone number for the purpose of contacting you to remind you about scheduled appointments, re-evaluations or other appointment related issues.
The use of this information is intended to make your experience with our office more efficient and productive.
If you choose not to authorize this information use your decision will have no adverse effect on your care from Dr. Handt or your relationship with our staff.

This notice is effective as of___________________ . This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

________________________________ ____________________________________ __________

Name (Printed please) Signature Date

If you are a minor, or if you are being represented by another party

_____________________________ _________________________________ __________

Personal Representative Printed Personal Representative Signature Date

____

Description of the authority to act on behalf of the patient.

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

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INSURANCE POLICIES & GUIDELINES

The purpose of this letter is to let you know how our office works in the handling of your insurance claims. We do this to help eliminate any questions while informing you of all our procedures and policies in advance. This better enable us to serve your health care needs effectively and efficiently. In this way, policies can be followed as intended.

We itemize all our procedures. The reason for this is to let the insurance company personnel know exactly what was done on each visit and why. In reporting to insurance companies, we are responsible to them on your behalf to accurately inform them as to your condition, status, any complications, exacerbations, unusual circumstances, etc., that would affect your recovery. We are also responsible for letting them know how long we anticipate your care will be, and at what frequency. All this involves a tremendous amount of staff and professional time and expense. However, we do this as a service to you. It lessens your burden of having to communicate with the insurance company, it lessens the responsibility and threat regarding when insurance no longer will cover care, and it makes care easier and more enjoyable for you. All we ask is your cooperation. Our usual procedures and their cost are the recommended fees set forth by the NYS insurance guidelines and are listed separately, a copy will be provided upon request.

Because we itemize and document every procedure in accordance with insurance protocol rather than just describe what is being done as an "office visit," the charges per visit can vary depending on level of documentation & procedures per visit for the actual office visit, plus any additional charges for all special procedures performed. **For various reasons, we know that there are a lot of charges that will not be paid** by your insurance company, i.e.: maximum dollar amount limits per visit, procedures that the policy does not cover, etc. However, we still have to bill customary fees for all services we perform as required by you insurance Co. to adequately communicate with the insurance company in your best interest. It is the nature of insurance companies to question and adjust reimbursement fees.

Our experience shows that an insurance company that receives billings that describe your visit to an office as an "adjustment" or an office visit, does not understand what is being performed on that visit and why. Some have taken the position that billings sent in this generic way, without any diagnostic criteria to objectively determine what adjustment is needed on that visit, is incomplete. Insurance companies are not familiar with the principles of Chiropractic, and they look on this practice in reporting the same way they would if an MD. were to just randomly give out shots or pills to every patient without fist determining whether or not that patient actually needed anything done on that visit.

Some companies pay 100%, some pay 90%, some pay 80%, some pay 50%, some pay for x-rays but not examinations, some pay for examinations but not x-rays, some pay only for an adjustment, some pay everything BUT the adjustments. MEDICARE often pays only for 12—15 visits a year, demanding that x-rays be taken but not paying for them nor the examinations the patient must have, and the list goes on and on. We only state this so that you are aware of the practices that exist within the insurance industry.

Family care: For those patients who choose NOT to participate in our Family program**, you are responsible for your DEDUCTIBLE and all CO-PAYMENTS** do toward your patient portion that your policy demands you must pay. If you have a special financial situation that makes this difficult or impossible for you, you have only to speak to one of the staff and arrangements will be made so you can receive the care you need at a fee you can afford. We cannot, however, read minds . . . you must tell us. Then we can help you!

When you choose to participate in our Family program, any charges that your insurance company does not pay ***(other than your deductible)*** will NOT be billed to you. Your co pay is covered by your financial plan. We still have to report to your insurance company in a manner that informs them what is being performed, whether we are paid for it or not. **We accept only those patients we truly feel we can help regardless of condition or financial ability!!** This policy allows us to care for everybody based on THEIR NEEDS .

ANY CORRESPONDENCE THAT YOU RECEIVE FROM YOUR INSURANCE COPANY MUST BE BROUGHT TO US SO THAT WE MAY HAVE A COPY OF IT FOR OUR RECORDS (often the patient receives information that is vital to processing a claim that never finds its way to the doctor's office, such as the explanation of benefits . . . (the stub attached to a check), a scheduled independent examination, a scheduled hearing, etc. We ask that you please help us by bringing all documentation to us as soon as you receive them.

Please understand it is our purpose to obtain maximum coverage towards your care from your insurance company. In this way, we can help everybody achieve great health through chiropractic. By fully participating in the above policies, you help make this possible.

Please sign your name below indicating that you have read the above and understand it. Thank you . . .

Name (Please print): ________________________________ Date:.________________________________

Signature: ________________________________ Witness: ________________________________

Chiropractic Office

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Chiropractic Office

AUTHORIZATIONS AND RELEASES

Patient name____ **Date**________________

Relationship To Insured Self Spouse Child Other

EMPLOYER	Company Name____________________________________ Occupation______________ Address____________________________ Phone____________ Full-time Part-time City State Zip
SPOUSE (PARENT)	Name____ Last Name First Name Initial Birth date____________ Social Security #__________________________________ Employer Name________________________________ Occupation_______________ Address______________________________________Phone_______________ City State Zip
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name____________________________________ Policy/Group #:___________________________ Effective Date:________________ Name of Insured: ____________________________ID #:______________________
SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name____________________________________ Policy/Group #:___________________________ Effective Date:________________ Name of Insured :____________________________ID #:______________________
MEDICAL AND LEGAL INFORMATION	Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? **Yes** **No** Your Initials:_______ If you answered yes, please fill out accident specific form, available at the front desk. Pregnant Yes No Pacemaker Yes No Family Physician____________________ Person to contact in emergency (Name and Phone #)_______________________________ Attorney____________________________________ Telephone:_________________ Address____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to New York Chiropractic Life PLLC all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

____________________________ __________ ____________________________ __________

Signature of Insured / Guardian Date Witness Date

Back Index

Patient Name ______________________ **Date** ____________

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score ☐

Neck Index

Patient Name ______________________________ ***Date*** ______________

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score ☐

Patient's Name: Medicare # (HICN):

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for –**

Items or Services:

X– rays, therapy, nutrition, supports, pillows, massage and maintenance care

Because:

These are not covered services under Medicare guidelines

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: $**_______________), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

☐ **Option 1. YES. I want to receive these items or services.**

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

☐ **Option 2. NO. I have decided not to receive these items or services.**

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

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

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 Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

OMB Approval No. 0938-0566 Form No. CMS-R-131-G (June 2002)

ABOUT MEDICARE COVERAGE

The government's Medicare program only pays Doctors of Chiropractic (DCs) for limited services. If your needed Chiropractic Adjustment (manipulation treatment) meets Medicare's rules, they will usually pay for it. There are three categories of Medicare services: 1) non-covered 2) always covered, and 3) perhaps covered.

NON-COVERED

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:

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:

- Adjustment on an area other than the spine - (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" code 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

A typical example of a Medicare COVERED service (or clinically needed) is when you are in much pain due to a bad spinal condition. You should also expect Medicare to cover and pay for your rehabilitation as long as you are improving. When you have a COVERED chiropractic spinal adjustment (manipulation treatment), it will be shown on your Medicare claim form and payment reports as either "98940", "98941", or "98942".

PERHAPS COVERED

Your Chiropractic Adjustment must be clinically needed according to Medicare. If Medicare thinks 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 due to any rules that they might have, we will let you know. We will give you a special Medicare form known as the Advance Beneficiary Notice (ABN).

STATEMENT OF UNDERSTANDING

I understand that I am personally financially responsible for all Medicare NON-covered services. I also understand that there could be times when my chiropractic adjustments might not be covered. If so, my doctor will let me know. I am also responsible for any annual deductibles or applicable copayments as required by Medicare.

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

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LONG-TERM AUTHORIZATION

You won't have to sign again during this time period. This authorization can be revoked upon your written request.

Patient Name: ______________________________ Medicare # (HICN): ____________________

Provider Name: ____

Provider Address: ____

Authorization Period: From : ____________ 200__ To:____________ 200__ *(must be completed to be valid)*

I request that payment under the medicare insurance program be made either to me or to the provider named above on any bills for services furnished to me during the effective period of this authorization, and I authorize the above named provider to release to the Social Security Administration or its intermediaries or carriers, or to any other payer for information needed to process claims. I further permit a copy of this authorization to be used in place of the original.

____ ____________________
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.