EASTLAKE CHIROPRACTIC AND MASSAGE CENTER, PS

PATIENT REGISTRATION

Patient: _____ Date of birth _____ Today's Date_____ ☐ Male ☐ Female
LAST FIRST MIDDLE

Address: _____ Social Security #: _____

City, State, Zip: _____ EMAIL:_____

Phone # (_____)_____ Work phone # (_____) _____Ext _____

Whom may we thank for referring to our office?:_____

Marital Status: ☐ M ☐ S # of Children _____ages_____ Spouse/Partner's Name: _____

Occupation: _____ Employer: _____

In Case of emergency, notify _____ Relationship _____Phone # (_____)_____

Address:_____Phone # (_____)_____

Medical Doctor Name:_____ **Clinic Name:**_____

Address:_____Phone # (_____)_____

INSURANCE : PLEASE SUPPLY INFORMATION FOR BOTH INSURANCE CARRIERS IF APPLICABLE

Is this an: _____ Auto Accident? _____ Work related ? _____ Other? Date of Injury: _____

Primary Carrier Name: _____ Secondary Carrier Name: _____

Phone # (_____) _____Policy /Claim # _____ Phone #: (_____) _____Policy/Claim #_____

Insured: _____DOB _____ Insured:_____ DOB _____

ID #: _____ Group # _____ ID #: _____Group # _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I also understand and agree that all services rendered me are charged to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered me will be immediately due and payable. I hereby agree that I will be assessed one percent (1%) charge per month on any fee not kept current.

Patient or Guardian's Signature: _____ Date: ____/____/_____

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Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

Chiropractic care centrally involves what is known as a chiropractic adjustment but also may involve some diagnostic or examination procedures if indicated. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns from hot or cold packs, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. It has been reported that chiropractic care can pose a rare risk of stroke or cervical vascular injury or even death.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Each of these treatment options poses its own related risk. Ask your primary care doctor about these risks. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____

Signature: _____ Date: _____

Parent or Guardian: _____

Signature: _____ Date: _____

Witness Name _____

Signature: _____ Date: _____

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PATIENT INTRODUCTION FORM

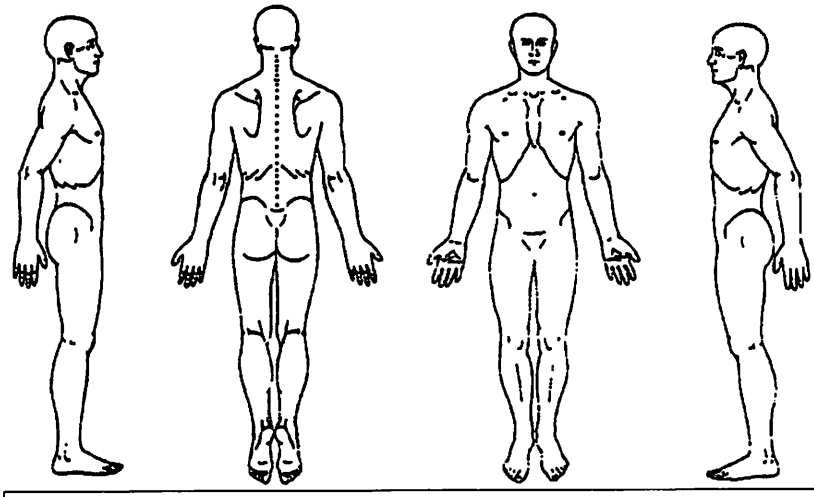
NAME_____ TODAY'S DATE___/___/_____

WOMEN–ANY POSSIBILITY YOU COULD BE PREGNANT? **Y / N** IF YES 1ST DAY OF LAST CYCLE___/___/___

REASON(S) FOR CONSULTING THIS OFFICE:_____

_____

_____



How often do you experience your symptoms?

___ Constantly (76-100% of the day)
___ Frequently (51-75% of the day)
___ Occasionally (26-50% of the day)
___ Intermittently (0-25% of the day)

Describe the pain (circle all that apply):

Deep	Superficial	Numb
Sharp	Burning	Tingling
Dull Achy	Throbbing	Shooting

How are your symptoms changing?

___ Getting Better
___ Not Changing
___ Getting Worse

Use the following scale to rate your pain=> **MILD MODERATE SEVERE DISABLING**
1 2 3 4 5 6 7 8 9 10+

Generally or **right now** = ____/10
When you feel the **best**: = ____/10
When you feel the **worst**:= ____/10

HAVE YOU RECEIVED CARE FOR YOUR CURRENT CONDITION? Y / N
IF YES, List any healthcare professionals seen for your current problem (s):_____

_____

Check the type of treatments you've had for your **current problem**(s):

___Ice ___Heat ___Physical Therapy ___Massage therapy ___Stretching ___Medication ___Surgery

___Chiropractic ___Exercise ___Acupuncture ___Other_____

Have you ever had these problems/symptoms before: **Y / N** Which_____

ON A SCALE FROM 1—10 WHICH OF THE BELOW EVERYDAY ACTIVITIES ARE IMPACTED BY YOUR SYMPTOMS? 1 = MILD AND 10 = SEVERE

___ Computer work ___ Sitting ___ Lifting ___Bending ___ Getting in/out of chair/bed

___ Standing ___ Walking ___ Running ___ Sleeping ___Reading ___ Exercise

___ Other_____

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WHICH OF THE FOLLOWING HAVE YOU BEEN EXPERIENCING DIFFICULTY WITH OR BEEN DIAGNOSED WITH: (PLEASE CHECK ALL THAT APPLY)?

___HEADACHES
___NECK PAIN
___NECK STIFFNESS
___BACK PAIN
___BACK STIFFNESS
___DISC PROBLEMS
___SHOULDER PAIN
___ARM PAIN
___ELBOW PAIN
___WRIST PAIN
___HAND/ FINGER PAIN
___TINGLING IN ARM/HAND
___COLD HANDS
___HIP PAIN
___LEG PAIN
___KNEE PAIN
___ANKLE PAIN
___FOOT/ TOE PAIN
___TINGLING IN LEGS/ FEET
___COLD FEET
___SWOLLEN ANKLES
___PAINFUL JOINTS
___ARTHRITIS
___NIGHT PAIN
___EXCESSIVE FATIGUE
___POOR DIET
___FAINTING
___NAUSEA
___NERVOUSNESS
___FREQUENT COLDS
___SINUS PROBLEMS
___ALLERGIES
___ASTHMA
___EAR INFECTIONS
___STOMACH PROBLEMS
___SWALLOWING
___CONSTIPATION
___DIARRHEA
___ABNORMAL STOOLS
___PAINFUL BOWEL MOVEMENTS
___KIDNEY PROBLEMS
___BLADDER PROBLEMS
___PROSTATE PROBLEMS
___MENSTRUAL PROBLEMS
___GALL BLADDER PROBLEMS
___LIVER PROBLEMS
___CHEST PAINS
___HIGH BLOOD PRESSURE
___LOW BLOOD PRESSURE
___HEART PROBLEMS
___HEART ATTACK/ DISEASE
___STROKE
___DIABETES
___ANEMIA
___THYROID PROBLEMS
___OSTEOPOROSIS
___CANCER
___DIZZINESS/VERTIGO
___BALANCE PROBLEMS
___COORDINATION PROBLEMS
___VISION PROBLEMS
___DEPRESSION

ANY CONDITION/CONCERN NOT LISTED ABOVE_____

Have you had any significant trauma in the past (auto accidents, sports injuries, falls, etc.): Y / N
If yes, give description / date of each:_____
_____

List any operations and dates of each:_____

List any diseases and dates of each:_____

Are you presently taking any medication: Y / N Is it for your current problem: **Y / N**
List any name(s), dosage and reason you are taking medication:_____
_____

Do you have any medication allergies? Y / N If yes, What?:_____

EXERCISE: ___ NEVER ___ LIGHT (1-2X per week) ___ MODERATE (3-4X per week) ___ INTENSE (5+X per week)

Types of exercise :_____

SMOKING STATUS: Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked
ALCOHOL STATUS: Every Day Drinker / Occasional Drinker / Former Drinker / Never Drank
RECREATIONAL DRUGS: Y / N WHAT AND HOW OFTEN?_____

RATE YOUR TYPICAL STRESS LEVEL (OVERALL): 1 2 3 4 5 6 7 8 9 10+
MILD MODERATE SEVERE DISABLING

HAVE ANY OF YOUR BLOOD RELATIVES BEEN AFFECTED BY THE FOLLOWING CONDITIONS: (Indicate which family member. For example: Father, mother, grandmother, grandfather, aunt, uncle, etc.)

_____RHEUMATOID ARTHRITIS _____HEART DISEASE _____HIGH BLOOD PRESSURE
_____ STROKE _____DIABETES _____CANCER
OTHER_____

What is your height and Weight? Height: ___/___ ___ Weight:_____ lbs

I have read and reviewed the information herein and represent that the same is true, correct and complete. I understand that the doctor is relying upon the information in rendering treatment.

Patient signature_____ Date:___/___/_____

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POLICIES AND PROCEDURES

<u>UNDERSTANDING INSURANCE BILLING:</u> (THIS IS IMPORTANT, PLEASE READ THOROGHLY AND ASK ANY QUESTIONS YOU NEED BEFORE SIGNING.)

Insurance can be a complicated affair. We want to spare you any surprises if we can. It is our hope to never have a bill come between us. Here are some important things to know about insurance companies:

1. **Your insurance company only pays for care that they feel is *<u>medically necessary</u>*. Insurance also dictates that your care must reduce or eliminate symptoms of an acute (<u>sudden</u>) condition; or a <u>sudden</u> exacerbation of a chronic condition. In both circumstances, there is often a <u>specific injury</u> to address.**

For example, although daily computer or yard work does cause aches and pains, your insurance co. **does not** consider these activities to be injurious for which they will pay for care on an **on-going basis, week after week, month after month**. However, if you reached for a file or lifted something heavy and felt a pain in your back or neck at that moment, your insurance co. **does** consider that to be a payable "event" and may approve an extended treatment plan for you to get well.

The best thing you can do to have your claim covered is to tell your provider how you are improving (or not) based upon your daily activities:

1) Can you sit with less pain?
2) Can you walk for longer periods?
3) Can you pick up your kids?
4) Can you do your workouts? Work in the yard? Paint? Type? Etc, etc.

2. **For massage**, to further prove medical necessity, **<u>a prescription/referral is required from a doctor</u>**. If you are receiving chiropractic here that can be done by the chiropractor. Minimally, the chiropractor would need to examine you.
3. **Massage and physical therapy are often a combined benefit** listed under rehabilitative services which usually also includes speech and occupational therapy etc. For example they may allow up to 24 visits for the above therapies. This is important to note because **<u>in our office the chiropractors will always use physical therapy techniques to facilitate the adjustment</u>**. It is a separate action when the chiropractor stretches, tractions, mobilizes, massages, uses heat or ice, or works the muscles before or after the actual manipulation of the spine. These actions are billed separately. **Some insurances count that as a PT visit. If you are getting PT from a physical therapist**

or receiving massage, you may not want to bill your insurance and instead pay for PT done by the chiropractor separately ($11). Please let the front desk know if you are interested in that alternative.

4. **Medicare (for reasons we do not agree with) will not cover examinations ($85) or x-rays ($85).** Examinations are required to prove medical necessity. Your supplemental insurance will also not cover these services. If you have a secondary insurance they will likely cover these services.

5. As a service to you, we will contact your insurance co. and ask what your benefits are in relation to chiropractic, massage, physical therapy, x-rays and orthotics. **The benefits that we relay to you are not a guarantee of payment.** Ultimately treatment here is your financial responsibility and we strongly suggest that you familiarize yourself with your plan.

6. **Cancellation policy:** We require 24 hours notice for cancelling or rescheduling a massage appointment. Your consideration for other patients and your massage therapist is appreciated. **Failure to provide 24 hour notice or not showing will result in a $50 fee. This is not covered by insurance.** If you are running late for your massage or chiropractic appointment, please call, we will do our very best to still see you.

7. **Acknowledgement of receipt of Notice of Privacy Practices:** I acknowledge that I have received a copy of Eastlake Chiropractic and Massage Center (ECC) "Notice of Privacy Practices". This notice describes how ECC may use and disclose my protected health information, certain restrictions on the use and disclosure of healthcare information and rights I may have regarding my protected health information.

I acknowledge that I have read and understand the above statements.

Signature _____ Date _____

Print Name _____