

WELCOME TO FALLS CHIROPRACTIC AND INJURY!

PATIENT INFORMATION (Most of the information below is required for insurance purposes)

DATE: ____ / ____ / ____

FIRST NAME: _____ M.I.: _____ LAST NAME: _____

DATE OF BIRTH: ____/____/____ CALLED NAME / NICKNAME: _____

ADDRESS: _____ SUITE OR APT #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE:(____) ____ - ____ CELL PHONE:(____) ____ - ____ Text ok? Y N

WORK NUMBER:(____) ____ - ____ (for **emergency** use only)

GENDER: (please circle one) MALE FEMALE

MARITAL STATUS:(please circle one) SINGLE MARRIED OTHER: _____

SOCIAL SECURITY #: _____ - _____ - _____

DRIVERS LICENSE #: _____ STATE ISSUED _____

WORK STATUS:(please circle one) EMPLOYED FULL-TIME STUDENT PART-TIME STUDENT

EMAIL _____ @ _____

INSURED INFORMATION (Required information if you, the patient, are **NOT** the policyholder)

Patient's relationship to the policyholder: (please circle one) Spouse Child Other _____

First name _____ M.I. _____ Last name _____

Social Security # _____ - _____ - _____ Date of Birth ____ / ____ / ____

Gender: (please circle one) Male Female

Referred By: _____

For continuity of care, we would like to send your primary care physician a copy of your initial exam/visit note and x-ray report (if applicable). Please provide your doctor information below:

Doctor Name _____

Practice name: _____

Address/Location name: _____

Phone #:(____) ____ - ____ Fax: (____) ____ - ____

_____**(Initial here)** *In providing the information above, I acknowledge and consent to the release of this information to my selected primary care physician/office.*

_____**(Initial Here)** *In reading this, I acknowledge that I have been informed that a most recent copy of the HIPAA Notice of Privacy Practices is available for me to review or receive a copy if I request one. I understand this office follows all current HIPPA compliance requirements.*

Patient Health Questionnaire (PHQ)

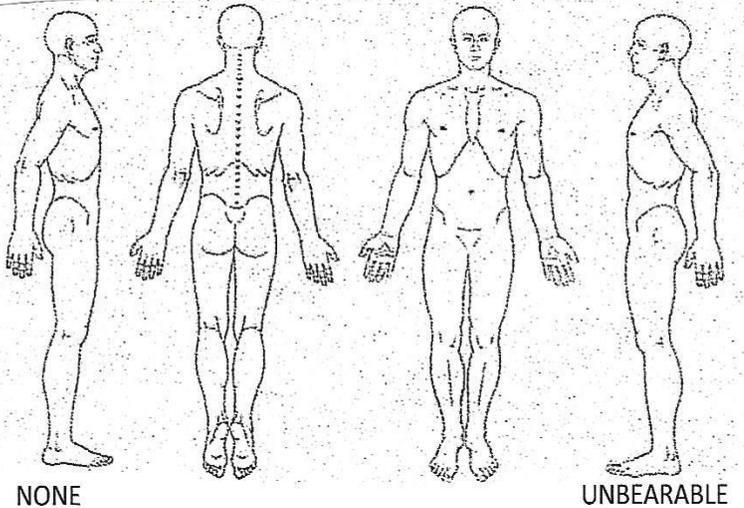
Patient Name _____

HISTORY OF PRESENT ILLNESS (99203: min of 4,99213:1-3)

1. Describe your CURRENT symptoms _____
- 2. When did your symptoms start (This CURRENT episode) _____
3. How did your symptoms begin? (I.E woke up with it, bent over, gradually etc...) _____

• On the body outline below, please indicate where you have pain or other symptoms: ↓↓↓↓:

- 4. 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)



- 5. What describes the nature of your symptoms:
___ Sharp ___ Shooting ___ Dull ache
___ Burning ___ Numbness ___ Tingling

• 6. Indicate the average intensity of your symptoms: 0 1 2 3 4 5 6 7 8 9 10

7. How much has the pain interfered with your normal activities of daily living, both home and work if applicable:

___ Not at all ___ A little bit ___ Moderately ___ Quite a bit ___ Extremely

• 8. What makes your symptoms WORSE? _____

• 9. What makes your symptoms BETTER? _____

10. What is your occupation? (helps determine mechanics related to issue) _____

___ Full Time ___ Part Time ___ Self Employed ___ Unemployed ___ Off work ___ Other

11. Have you had similar symptoms in the past? ___ YES ___ NO

12. If you have received treatment in the past, who did you see? ___ This office (pprox.. when?) _____

___ Medical Doctor ___ Physical Therapist ___ Other Chiropractor ___ Other (_____)

13. Have you seen anyone else for this episode of symptoms? ___ Medical Doctor ___ Other Chiropractor ___ Other

What treatment did you receive and when? _____

What tests have you had for your symptoms and when were they performed? ___ XRAY, Date _____

___ CT SCAN, Date _____ ___ MRI, Date _____ Other _____

Patient Signature _____ Date: ____ / ____ / ____

Patient Name: _____ Date: ____ / ____ / ____

Review of Systems: *Please check box if applicable, check NO if none please*

(99203: 2 pertinent, 99213: 1 pertinent)

Cardiovascular			No	Respiratory			No	Allergic/Immunologic			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								Ear, Nose and Throat			No
Jaw Pain				Eyes			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				Psychiatric			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				Gastrointestinal			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				Hematologic			No				
Pinched Nerves					Past	Present		Musculoskeletal			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											

Past Medical History:

PSFH (99203: 1 pertinent)

List all current prescribed (**INCLUDE Dosage and Frequency**), over the counter medications and supplements: _____

(Continued next page please)

Height: _____ Weight: _____

Allergies: No Known Allergies _____ Latex _____ Medication (name) _____

Other allergy _____

List all surgeries in your lifetime and approx. year: _____

List all serious illness in your lifetime: _____

List all significant trauma or accidents in your lifetime: _____

Please include approximate dates/year on the above listed

Family Medical History for Heredity and Risk:

Indicate if an immediate family member (parents, grandparents, sibling) currently has or has had any of the following:

__ Diabetes __ Scoliosis __ Lupus __ Cancer Relationship to you?:

Social History:

Alcohol Usage _____ frequently _____ occasionally _____ socially _____ never

Tobacco _____ frequently _____ occasionally _____ socially _____ never

Exercise _____ frequently _____ occasionally _____ sporadically

Exercise Type _____ walking frequency/distance _____

_____ running frequency/distance _____

_____ swimming frequency/laps _____

_____ weights type and reps _____

_____ classes type and frequency _____

Other concerns or issues you would like to address:

PATIENT SIGNATURE: _____

PATIENT NAME PRINT: _____

Office use ONLY please: Blood Pressure _____/_____ Pulse _____ Temp _____

INFORMED CONSENT FORM

PATIENT NAME: _____

DATE: _____

To the patient: Please read this entire document prior to signing it. It is very important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

spinal manipulative therapy palpation vital signs
 range of motion testing orthopedic testing basic

Neurological

muscle strength testing postural analysis neurological testing
 ultrasound hot/cold therapy Electrical Stim
 radiographic studies mechanical traction
 Other _____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

SEE NEXT PAGE FOR MORE INFORMATION AND SIGNATURES

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [] or have had read to me [] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with **Richard A. Laviano D.C.** and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient Name Print

Richard A. Laviano D.C.
Doctor Name Print

Patient Signature

Doctor Signature

Signature of Parent or Guardian

Date

Date

FALLS CHIROPRACTIC AND INJURY INSURANCE FINANCIAL POLICY AGREEMENT

PARTICIPATING INSURANCE COMPANY: By signing below, I understand that I am responsible for the entire balance of my bill. Falls Chiropractic and Injury will extend credit for the portion that is expected to be covered by your insurance. Therefore, I agree to the following office policy requirements:

1. To pay in full (the contracted amount) until my yearly deductible is satisfied (if applicable).
2. To pay my co pay percentage of billed service(s) each visit (if applicable).
3. To pay my flat co pay per visit according to the co pay provision of my policy (if applicable).
4. To pay the balance due on each claim after the receipt of any insurance payment upon notification from this office. For plans in which we participate, this could include non-covered items or services or if indicated patient responsibility portions not collected at the time of service. Any over payment by patient and insurance will be applied to your next date of service unless you request a refund.
5. The office makes every effort to ensure quality care is given, which may include after hours/weekend calls. If your doctor advises or you request to meet at the office during this time, there may be an **additional** (to the adjustment and/or treatment) charge of **\$70.00**. This is not typically covered by most insurance plans and will be YOUR responsibility.
6. If your doctor is out of town or not available to be on call, we will have made arrangements with another chiropractic office. If they see you on an urgent basis, they may treat you as a new patient and will be billing your insurance (if they are participating with your insurance, it is your responsibility to check if they are on your plan) or billing yourself as such.
7. **We require a 4-hour notice for appointment cancellations and the missed appointment fee is \$50. We have a time and date stamp on our answering machine service so feel free to leave a message at any time.**
8. If you have an HMO or Medicaid policy that requires a referral from your primary care doctor, it is YOUR responsibility to obtain proper referral/authorization **prior** to your visit. We will be happy to assist you if needed, but we are not responsible for missing referral denials. Many primary care doctors require you see them before they will issue a referral authorization and will not retroactively supply one.
9. If for any reason you have a patient balance due, you will receive a patient statement. If you have a zero patient balance, you will not receive a statement. There will be a 1.5% monthly finance charge that will accrue on any patient balance over 30 days past due.
10. **PLEASE NOTE: AN EXAM CHARGE WILL APPLY IF THERE IS A NEW INCIDENT OR INJURY OR IF YOU HAVE NOT BEEN IN THE OFFICE FOR AN ONGOING TREATMENT PLAN. A RE-EVALUATION EXAM IS CHARGED EVERY 12-16 VISITS. YOU ARE CONSIDERED A NEW PATIENT IF YOU HAVE NOT BEEN SEEN FOR 3 YEARS OR MORE.** We will require updated paper work and insurance cards at our discretion so that our charts conform to your insurance, State Dept of Insurance requirements for auditing purposes.

ASSIGNMENT, AUTHORIZATION AND POLICY STATEMENT

I hereby assign the benefits that I am eligible to receive for the care rendered in this office, to the office. In consideration of this assignment the office extends credit. I authorize the office to release any information, per HIPPA guidelines, to any insurance company, adjuster, or attorney that will assist in the payment of claim(s). I fully understand and agree that my insurance policies are an arrangement between an insurance carrier and myself. I will be responsible for any expenses not paid by insurance, per what is allowed with our contract. A photocopy of this form shall be considered as valid as the original. This policy form has no expiration date unless received revocation in writing.

By signing below, I acknowledge that I have fully read, understand and agree to this policy.

Patient PRINTED Name: _____

Patient SIGNATURE: _____

Date of signature: ____/____/____