APPLICATION FOR CARE AT CROSSROADS CHIROPRACTIC

Today's Date:_____ Whom may we thank for referring you? _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____ Age: _____ ☐ Male ☐ Female

Address: _____ Apt:_____ City: _____ State: ___ Zip:_____

Email: _____ Home Phone: _____ Mobile Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Do you have insurance? ☐ Yes ☐ No

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ # of Children: _____ Ages of Children: _____

Name & Number of Emergency Contact: _____Relationship: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to our office: **Primary**: _____

Secondary: _____ **Third**: _____ **Fourth**: _____

On a scale of 1 to 10, with 10 being the worst pain and 1 being the least, rate your above complaints by circling a number:

Primary or chief complaint:	1	2	3	4	5	6	7	8	9	10
Secondary complaint:	1	2	3	4	5	6	7	8	9	10
Third Complaint:	1	2	3	4	5	6	7	8	9	10
Fourth Complaint:	1	2	3	4	5	6	7	8	9	10

When did the problem(s) begin? _____ When is it at its worst? ☐ AM ☐ PM ☐ Overnight

How long does it last? ☐ Constant ☐ On and off throughout the day ☐ Comes and goes throughout the week

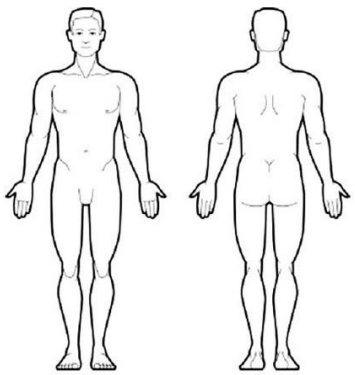
How did this injury happen? _____

Has this condition been treated by anyone in the past? ☐ Yes ☐ No If yes, when? _____

By whom? _____ How long under care? _____ Outcome? _____

Please mark the areas on the diagram with the following letters to describe your symptoms:

R = Radiating **B** = Burning **D** = Dull **A** = Aching **N**= Numbness **S** = Sharp/Stabbing **T** = Tingling



What relieves your symptoms? _____

What makes them feel worse? _____

List of Restricted Activities:	Normal Activity Level:	Current Activity Level:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there any other injuries to your spine, minor or major, that the doctor should know about? ☐ Yes ☐ No

If yes, please explain:_____

HISTORY

Have you suffered with this or similar problems in the past? ☐ Yes ☐ No If yes, how many times? _____

When was the last episode? _____ Did you try treatment? ☐ Yes ☐ No

If yes, what kind? _____ For how long? _____Results? ☐ Favorable ☐ Not Favorable

Explain: _____

Please list any allergies you have to medications:

_____

If you have been diagnosed with any of the following, please indicate with a **P** for "in the Past" or a **C** for "currently have"

☐ Broken Bone	☐ Dislocations	☐ Tumors	☐ Rheumatoid Arthritis
☐ Fracture	☐ Disability	☐ Cancer	☐ Osteoarthritis
☐ Heart Attack	☐ Diabetes	☐ Cerebral Vascular	☐ Other Serious Condition:

Surgeries:_____ How long ago?_____ Type of care received:_____

Injuries: _____ How long ago?_____ Type of care received:_____

Childhood Disease:_____ How long ago?_____ Type of care received:_____

Adult Disease: _____ How long ago?_____ Type of care received:_____

SOCIAL HISTORY

Smoking ☐ Cigars ☐ Cigarettes ☐ Pipe How often? ☐ Daily ☐ Occasionally ☐ Never

Alcohol Consumption How often? ☐ Daily ☐ Occasionally ☐ Never

Recreational Drug Use: How often? ☐ Daily ☐ Occasionally ☐ Never

FAMILY HISTORY

Does anyone in your family suffer from the same condition(s)? ☐ Yes ☐ No

If yes, who? ☐ Grandfather ☐ Grandmother ☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter

Any other hereditary conditions the doctor should be aware of? _____

I, the undersigned, attest that the answers given are true and accurate to the best of my knowledge. I hereby authorize payment to be made directly to Crossroads Chiropractic and Wellness Center for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize use of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Crossroads Chiropractic and Wellness Center for any and all services I receive at this office. I also understand and agree that my email address will be added to the provider's newsletter list and that I may unsubscribe at any time.

Patient Name (Please Print): _____

Patient or Authorized Person's Signature:_____ Date:_____

ACTIVITIES OF LIFE

Please identify with an "x" how your current condition is affecting your ability to carry out routine activities.

Carrying Groceries		No Effect		Painful (can do)		Painful (limits)		Can Not Perform
Sit-to-Stand		No Effect		Painful (can do)		Painful (limits)		Can Not Perform
Climbing Stairs		No Effect		Painful (can do)		Painful (limits)		Can Not Perform
Pet Care		No Effect		Painful (can do)		Painful (limits)		Can Not Perform
Driving		No Effect		Painful (can do)		Painful (limits)		Can Not Perform
Extended Computer Use		No Effect		Painful (can do)		Painful (limits)		Can Not Perform
Household Chores		No Effect		Painful (can do)		Painful (limits)		Can Not Perform
Lifting Children		No Effect		Painful (can do)		Painful (limits)		Can Not Perform
Reading/Concentration		No Effect		Painful (can do)		Painful (limits)		Can Not Perform
Bathing		No Effect		Painful (can do)		Painful (limits)		Can Not Perform
Dressing		No Effect		Painful (can do)		Painful (limits)		Can Not Perform
Shaving		No Effect		Painful (can do)		Painful (limits)		Can Not Perform
Sexual Activities		No Effect		Painful (can do)		Painful (limits)		Can Not Perform
Sleep		No Effect		Painful (can do)		Painful (limits)		Can Not Perform
Static Sitting		No Effect		Painful (can do)		Painful (limits)		Can Not Perform
Static Standing		No Effect		Painful (can do)		Painful (limits)		Can Not Perform
Yard Work		No Effect		Painful (can do)		Painful (limits)		Can Not Perform
Walking		No Effect		Painful (can do)		Painful (limits)		Can Not Perform

If you have experienced any of the below, please mark them with a "**P**" for "in the **past**" or a "**C**" for "**currently** have":

	Headache		Pregnant		Painful Joints		Mood Changes
	Neck Pain		Frequent Colds		Skin Problems		High Blood Pressure
	Jaw Pain (TMJ)		Frequent Flus		Dizziness		Low Blood Pressure
	Shoulder Pain		Epilepsy		Loss of Balance		Prostrate Problems
	Upper Back Pain		Tremors		Fainting		Impotence
	Mid Back Pain		Chest Pain		Blurred Vision		Sexual Disfunction
	Low Back Pain		Pain w/ Cough		Ringing in Ears		Digestive Problems
	Hip Pain		Foot Problems		Hearing Loss		Menopausal Problems
	Back Curvature		Knee Problems		Depression		Menstruation Problems
	Scoliosis		Sinus Problems		Irritable		PMS
	Learning Disability		Eating Disorder		Trouble Sleeping		Numb/Tingling Arms
	Ulcers		Heartburn		Heart Problems		Numb/Tingling Hands
	Asthma		Difficulty Breathing		Lung Problems		Numb/Tingling Fingers
	Kidney Trouble		Liver Trouble		Hepatitis (A, B, C)		Numb/Tingling Legs
	Allergies		ADD / ADHD		Bed Wetting		Numb/Tingling Feet
	Colon Trouble		Diarrhea		Constipation		Numb/Tingling Toes

List any medications you take: _____

_____

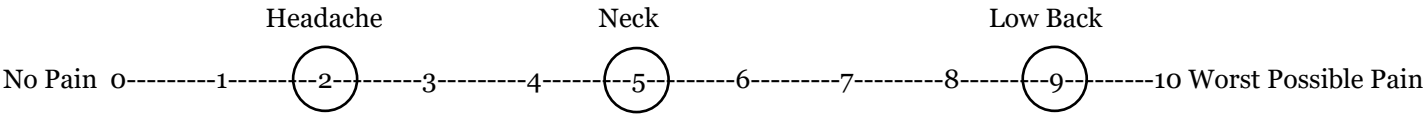
_____

_____

Please Read Carefully:

Instructions: Please circle the number that best describes the question being asked. If you have more than one complaint, please answer each question for each complaint, indicating the score for all complaints.

Example:



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1. **What is your pain RIGHT NOW?**

No Pain 0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10 Worst Possible Pain

2. **What's your TYPICAL or AVERAGE pain?**

No Pain 0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10 Worst Possible Pain

3. **What is your pain level at its BEST (How close to "0" does it get at its best)?**

No Pain 0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10 Worst Possible Pain

4. **What is your pain level at its WORST (How close to "10" does it get at its worst)?**

No Pain 0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10 Worst Possible Pain

OTHER COMMENTS:

_____

_____

_____

What are your **TOP 3 HEALTH GOALS**?

1. _____
2. _____
3. _____

Crossroads Chiropractic and Wellness Center

Informed Consent

Regarding: Chiropractic Adjustments, Modalities, and Therapeutic Procedures

Chiropractic care, like all forms of healthcare, holds certain risks. While the risks are most often very minimal, in rare cases complications such as sprain/strain injuries, irritation of disc condition and, although exceedingly rare, minor fractures and risk of stroke, which occurs at a rate of between 1 in 1 million to 1 in 2 million, have been associated with chiropractic adjustments.

I understand that the above list of items is not inclusive of all possible risks associated with chiropractic care and, after careful consideration, I do hereby consent to treatments by any means, method, and/or techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care, and I voluntarily assume all risks. I acknowledge that, like in all forms of healthcare, results are not guaranteed.

_____ _____

Patient or Authorized Person's Signature Today's Date

Regarding: X-Rays/Imaging Studies

During your examination, the doctor may feel that x-rays will be needed in order to provide your treatment. Diagnostic x-rays provide the doctor with valuable information that cannot be evaluated otherwise.

I understand that modern digital x-ray equipment exposes patients to a very low dose of radiation. After careful consideration, I hereby consent to have the x-ray examination the doctor has deemed necessary for my case.

_____ _____

Patient or Authorized Person's Signature Today's Date

FEMALES ONLY regarding the possibility of pregnancy

☐ The first day of my last menstrual cycle was _____ (Date)

This is to certify that, to the best of my knowledge, I am **NOT** pregnant. The doctor and staff of Crossroads Chiropractic and Wellness Center have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

_____ _____

Female Patient or Authorized Person's Signature Today's Date

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PERSUE PERSONAL INJURY, WORK COMP, ERISA, AND OTHER LEGAL CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE.

Provider Name: Dr. Mark Domanski

Clinic Name: Crossroads Chiropractic and Wellness Center

Clinic Address: 320 East Montgomery Crossroad, Suite 30, Savannah, GA 31406

I hereby assign to the above-named provider, hereinafter referred to as "my provider," my designated authorized representative, all medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment directly to my provider for services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered and paid by insurance. I understand that I maintain responsibility for obtaining any required referrals, preauthorization, or any other applicable insurance coverage requirements.

Should I involve an attorney in my case, I hereby authorize and direct my attorney and/or representative to provide Provider with any proceeds, judgement, verdict and/or thing of value, or any portion thereof, prior to dissemination of said proceeds, judgement, verdict and/or thing of value to any other person or entity, to compensate Provider in full for any services rendered to me and/or my dependents.

I authorize the use of my signature on all insurance submissions and payments. In the event that any attorney, insurance company, or any other third party is obligated to make payment to me or to my provider, I hereby assign and transfer to my provider any cause of action or other legal right(s) which may exist on my behalf and expressly authorize my provider to litigate, compromise, settle or otherwise resolve such claim as my provider exclusively deems appropriate.

I hereby authorize my provider to release healthcare information to any attorney, insurance company, or any applicable third party which is necessary to facilitate payment under the terms of this agreement. I further authorize any such applicable party to release any information relevant to the processing of a claim for reimbursement directly to my provider or its authorized representative. Such information can include, but is not limited to, insurance contracts, plans, booklets, summaries or any other materials which I am legally entitled to receive.

I acknowledge and agree that this assignment of benefits and/or right to compensation for treatment shall not be rescinded or revoked by myself, my attorney or anyone who claims to represent me. I understand that I am responsible for all charges submitted for services rendered to me by my provider, and that payment by me is not contingent upon any settlement, judgment, or verdict which I may eventually obtain for payment of outstanding charges.

A photocopy of this assignment/agreement shall be considered as valid as the original. A photocopy of any insurance claim(s) shall also be valid and have the same effect as the original.

_____ _____

Patient or Authorized Person's Signature Today's Date

Crossroads Chiropractic and Wellness Center

NOTICE OF PRIVACY PRACTICE AND POLICIES

This office is required to notify you in writing that, by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information and the potential circumstances under which, by law or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Once you have read this notice and signed the following page, you are welcome to tear out this page and keep it for your records. Should you choose not to take this page, please review it thoroughly before leaving. The signature page following must be turned into the reception desk along with the rest of your paperwork

Permitted Disclosures:

1. Treatment purposed – discussion with other healthcare providers involved in your care
2. Inadvertent Disclosures – open treating areas mean open discussion. If you need to speak privately to the doctor, please let our staff know so that we can place you in a private consultation room.
3. For payment purposes – to obtain payment from your insurance company or any other collateral source
4. For workers compensation purposes – to process a claim or aid in investigation
5. Emergency – in the event of a medical emergency, we may notify a family member
6. For public health and safety – in order to prevent or lessen a serious or imminent threat to the health or safety of a person or persons or the general public.
7. To government agencies or law enforcement – to identify or locate a suspect, fugitive, material witness, or missing person.
8. For military, national security, prisoner and government benefits purposes
9. Deceased persons – discussions with coroners and medical examiners in the event of a patient's death
10. Telephone calls or emails and appointment reminders – we may call your home and leave messages regarding missed appointments or apprise you of changes in practice hours or upcoming events.
11. Change of ownership – in the event this practice is sold, the new owners would have access to your PHI

Your rights:

1. To receive an accounting of disclosures
2. To request mailings to an address different than residence
3. To request restrictions on certain uses and disclosures and to whom we release information, although we are not required to comply. If we agree, the restriction will be in place until we receive written notice of your intent to remove the restriction.
4. To request amendments to information. However, like restrictions, we are not required to agree to them.
5. To obtain one (1) copy of your records, timely notice (72 hours) is required. Copying and postage fees may apply.

Refunds and Cancellation Policy:

Requests for refunds must be submitted in writing and will be reviewed upon receipt. If a refund is payable, it will be processed and a credit will be applied to your credit card or paid by check within 30 days of request.

In situations where insurance has been applied: A quote of benefits is not a guarantee of payment. Your claim will process according to your plan. If your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received. Once processed and applied, any refund will be issued in accordance with our refund policy.

Cancellation of a care plan negates extended discounts, and our standard office fee schedule will be applied to all services rendered. You are expected to do therapies (traction, rehab, wobble chair, vibration plate, etc.) when and as instructed. Should you choose to skip any or all therapies during a visit to the office, you must inform the front desk receptionist before leaving the office.

Returns and Exchanges:

Home Care Kits will not be eligible for refund, exchange, or credit.

Complaints:

If you wish to make a formal complaint about how we handle your health information, please call the office at 912-353-7611 to make an appointment to speak to the appropriate person.

Crossroads Chiropractic and Wellness Center

NOTICE OF PRIVACY PRACTICE AND POLICIES continued

I have received a copy of Crossroads Chiropractic and Wellness Center's NOTICE OF PRIVACY PRACTICE AND POLICIES. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights to the doctor. I further understand that this office reserves the right to amend this NOTICE OF PRIVACY PRACTICE AND POLICIES at any time in the future and will make the provisions effective for all information that it maintains, past and present.

I understand that I have been given the opportunity to discuss any of my concerns and questions about this notice and the privacy of my healthcare information.

Patient Name (Please Print Clearly): _____

Patient Date of Birth: _____

_____ _____

Patient or Authorized Person's Signature Today's Date