Downtown Chiropractic
793 S Main St. Suite A Lapeer, MI 48446
(810) 664-3333
Confidential Information

Patient Information

Patient Name:_____ Main compliant:_____
Address:_____ Home Phone:_____
City: _____ Zip Code:_____ Cell Phone:_____
SS#_____ Email:_____
Date of Birth:_____ Marital Status: M S W D
Occupation:_____ Employer:_____

Insurance information

Insurance company:_____ Ins. Phone number:_____
ID number:_____ Group number:_____
Policy Holders name:_____Policy holder DOB:_____
Are your present symptoms or condition related to an auto injury, work injury, or other injury where another party might be responsible: YES or NO

Family Physician:_____ Address:_____
Physician phone number:_____ (May we send them your health info YES or NO)
Emergency contact (Name and Phone number):_____
Are you a veteran: YES or NO
Have you been to a chiropractor YES or NO If yes, where: _____
Have you had X-RAY, MRI, or CT in the past year: YES or NO If yes where:_____
List any surgical operations you have had followed by the year/s they were done:

_____

Serious Illness or Injuries you have had followed by the the year/s it was present:

_____

Do you have a pacemaker? YES or NO Do you have a hip and/or knee replacement? YES or NO
What medications are you taking (Circle only those that apply):
Pain killers - Insulin - Blood pressure - Muscle relaxers - Birth control - Other:_____
What is your Goal in our office:_____
Who referred you to our office or where did you hear about us:

_____

Please sign stating you understand all the information above is accurate to the best of your knowledge.

Signature: _____ Date:_____

Appendix 2
"Good Faith Estimate for Health Care Items and Services" Under the No Surprises Act

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

Keep the estimate in a safe place so you can compare it to any bills you get later. After you get a bill for the items or services, if the billed amount is $400 or more above the good faith estimate, you may be eligible to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill or ask if there is financial assistance available.
You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises you

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

Signature: _____ Date: _____

By signing, Surprises I have Act. I read, understood and acknowledged the "Good Faith Estimate for Health Care Items and Services" Under the No Surprise Act. I understand that Downtown Chiropractic created a price estimate with information given to us.

Downtown Chiropractic Terms of Acceptance

The goal of Downtown Chiroptactic is to enable patients to gain control of their health. To attain this, we believe communication is the key. There are often topics that are hard to understand, and we hope this document will clarify those issues for you. Please read below, and if you have any questions, please feel free to ask one of our staff members.

Informed Consent

Upon presenting to the chiropractic physician, the patient grants permission and authority for care in accordance with the chiropractor's diagnosis and analysis. Chiropractic adjustments and other clinical procedures are generally beneficial and rarely cause complications. On rare occasions, underlying physical conditions, deformities, or pathologies may increase susceptibility to injury. Downtown Chiropractic will not administer treatment if aware that such care may be contraindicated. It is the patient's responsibility to disclose, or to determine through appropriate healthcare procedures, any latent pathological defects, illnesses, or deformities that may not otherwise be known to the chiropractic physician. The chiropractor offers specialized, complementary healthcare services and is licensed to collaborate with other healthcare providers as part of your overall healthcare regimen. If I am accepted as a patient at Downtown Chiropractic, I authorize the physicians to proceed with any treatments they deem necessary. Associated risks regarding chiropractic treatment will be explained to me upon request.

Missed Appointments

There is a possible fee charged for all appointments that are not canceled 24 hours prior to the scheduled visits.

Women ONLY

To the best of my knowledge, **circle one** (I am/ I am NOT pregnant) and **circle one** (give my permission/ do not give permission) to x-ray me for diagnostic interpretation.

Consent to Evaluate and Treat a Minor ONLY

I, _____being the parent or legal guardian of _____,have read and fully understand the above terms of acceptance and here by grant permission for my child to receive care at Downtown Chiropractic.

Communications

In the event that we would need to communicate your healthcare information, to whom may we do so?

Name, number, and relationship:_____

May we leave messages regarding your personal healthcare information on home answering machines, voicemails, text messaging, email? Yes () No ()

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy. Upon request, I will be given a copy.

Signature: _____ Date:_____

NECK QUESTIONNAIRE
(Only check 1 per question)

1. **PAIN INTENSITY**
☐I have no neck pain at the moment.
☐The pain is very mild at the moment.
☐The pain is fairly severe at the moment,
☐The paln Is very severe at the moment.
☐The pain is the worst imaginable at the moment.

2. **PERSONAL CARE** (e.g. Washing, Dressing)
☐I can look after myself normally without causing extra neck pain.
☐I can look after myself normally, but it causes extra neck pain.
☐It is painful to look after myself, and I am slow and careful.
☐I need some help but manage most of my personal care.
☐I need help every day in most aspects of self care
☐I don't get dressed, I was with difficulty and stay in bed.

3. **LIFTING**
☐I can lift heavy weights without extra neck pain.
☐I can lift heavy weights but it gives extra neck pain.
☐Neck pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table.
☐Neck pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐I can lift very light weights only due to neck pain
☐I cannot lift or carry anything at all due to neck pain.

4. **READING** (looking down e.g. on phone)
☐I can read as much as I want with no neck pain.
☐I can read as much as I want with slight neck pain.
☐I can read as much as I want with moderate neck pain.
☐I can't read as much as I want because of moderate neck pain.
☐I can't read as much as I want because of severe neck pain.
☐I can't read at at all due to neck pain.

5.**HEADACHES**
☐I have no headaches at all.
☐I have slight headaches that come Intrequently.
☐I have moderate headaches that come infrequently.
☐I have moderate headaches that come frequently.
☐I have severe migraine headaches that come frequently.
☐I have migraine headaches almost all the time.

6. **CONCENTRATION** (due to neck pain)
☐*I can concentrate fully without difficulty.*
☐I can concentrate fully with slight difficulty.
☐I have a fair degree of difficulty concentrating.
☐I have a lot of difficulty concentrating.
☐I have a great deal of difficulty concentrating.
☐I can't concentrate at all.

7. **WORK**
☐I can do as much work as I want.
☐I can only do my usual work, but no more.
☐I can do some of my usual work, but no more.
☐I can't do my usual work.
☐I can hardly do any work at all.
☐I can't do any work at all.

8.**SLEEPING**
☐I have no trouble sleeping.
☐My sleep is slightly disturbed for less than 1 hour.
☐My sleep is mildly disturbed for up to 1-2 hours,
☐My sleep is moderately disturbed for up to 2-3 hours.
☐My sleep is greatly disturbed for up to 3-5 hours.
☐My sleep is completely disturbed for up to 5-7 hours.

9. **DRIVING**
☐I can drive my car without neck paln.
☐I can drive my car with only slight neck pain.
☐I can drive as long as I want with moderate neck pain.
☐I can't drive as long as I want because of moderate neck pain.
☐I can hardly drive at all because of severe neck pain.
☐I can't drive my care at all because of neck pain.

10. **RECREATION**
☐I am able to engage In all my recreational activities with no neck pain at all.
☐I am able to engage in all my recreational activities with some neck pain.
☐I am able to engage in most, but not all of my recreational activities because of pain in my neck.
☐I am able to engage only a few of my recreational activities because of neck pain.
☐I can hardly do recreational activities due to neck pain.

FOR STAFF

SCORE:

LOWER BACK QUESTIONNAIRE (Only check 1 per question)

1. **PAIN INTENSITY**
☐I can tolerate the pain I have without having to use pain killers
☐The pain is bad but I manage without taking pain killers
☐Pain killers give complete relief from pain
☐Pain killers give moderate relief from pain
☐Pain killers give very little relief from pain
☐Pain killers give me no relief

2. **PERSONAL CARE** (e.g. Washing, Dressing)
☐I can look after myself normally without causing extra pain
☐I can look after myself normally but it causes extra pain
☐It is painful to look after myself and I am slow and careful
☐I need some help but manage most of my personal care
☐I need help every day in most aspects of self care
☐I don't get dressed, I was with difficulty and stay in bed

3. **LIFTING**
☐I can lift heavy weights without extra pain
☐I can lift heavy weights but it gives extra pain
☐Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table
☐Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
☐I can lift very light weights
☐I cannot lift or carry anything at all

4. **WALKING**
☐Pain does not prevent me walking any distance
☐Pain prevents me walking more than one mile
☐Pain prevents me walking more than ½ mile
☐Pain prevents me walking more than 1/4 mile
☐I can only walk using a stick or crutches
☐I am in bed most of the time due to pain

5. **SITTING**
☐I can sit in any chair as long as I like
☐I can only sit in my favorite chair as long as I like
☐Pain prevents me from sitting more than one hour
☐Pain prevents me from sitting more than ½ hour
☐Pain prevents me from sitting more than 10 minutes
☐Pain prevents me from sitting at all

6. **STANDING**
☐I can stand as long as I want without extra pain
☐I can stand as long as I want but it gives me extra pain
☐Pain prevents me from standing for more than one hour
☐Pain prevents me from standing for more than 30 minutes
☐Pain prevents me from standing for more than 10 minutes
☐Pain prevents me from standing at all

7. **SLEEPING**
☐Pain does not prevent me from sleeping well
☐I can sleep well only by using medication
☐Even when I take medication, I have less than 6 hrs sleep
☐Even when I take medication, I have less than 4 hrs sleep
☐Even when I take medication, I have less than 2 hrs sleep
☐Pain prevents me form sleeping at all

8. **SOCIAL LIFE**
☐My social life is normal and gives me no extra pain
☐My social life is normal but increases the degree of pain
☐Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e, dancing, etc.
☐Pain has restricted my social life and I do not go out as often
☐Pain has restricted my social life to my home
☐I have no social life because of pain

9. **TRAVELING**
☐I can travel anywhere without extra pain.
☐I can travel anywhere but it gives me extra pain.
☐Pain is bad, but I manage journeys over 2 hours
☐Pain restricts me to journeys of less than 1 hour.
☐Pain restricts me to short necessary journeys under 30 minute.s
☐Pain prevents me from traveling except to the doctor or hospital.

10. **EMPLOYMENT/ HOMEMAKING**
☐I can stand as long as I want but it gives me extra pain
☐Pain prevents me from standing for more than one hour
☐Pain prevents me from standing for more than 30 minutes
☐Pain prevents me from standing for more than 10 minutes
☐Pain prevents me from standing.

FOR STAFF

SCORE: