edgewood chiropractic center

1114 West Cook Road
Fort Wayne IN 46825
Office: 260-489-5588
Fax: 260-489-1819
Website: www.edgewoodchiropracticcenter.com
Email: edgewoodchiropractic@comcast.net

Welcome to Edgewood Chiropractic Center

We are excited to provide the following services as we walk with you through your chiropractic journey.

IF you intend to utilize any insurance benefits, it is imperative that you verify coverage for the following services. Please call the member services number listed on your insurance card and ask if you plan covers chiropractic care. The questions below are a guide to assist you:

1. Is chiropractic care part of my insurance plan?	**YES**	**NO**
2. Is there a limit to the number of visits allowed per year?	**YES (#) _____**	**NO**
3. Do you require any pre-authorization or treatment notes?	**YES**	**NO**
4. Are the CPT Codes below covered?	**YES**	**NO**
5. What is my co-pay / co-insurance?	_____	
6. What is my deductible / out of pocket max?	_____	

PLEASE NOTE: Benefit inquiries are not a guarantee of insurance coverage. ***Ultimately, you are financially responsible for any services rendered at any medical facility***. In order to continue to accept insurance, ECC is requesting that all patients take an ACTIVE PART in all aspects of their health care coverage.

EXAMS:	**COVERED**	
CPT Code 99202: Office visit for the evaluation & management of a new patient ($80)	**YES**	**NO**
CPT Code 99212: Office visit for the evaluation & management of an established patient ($65)	**YES**	**NO**
ADJUSTMENTS:		
CPT Code 98940: Chiropractic manipulative treatment (CMT); Spinal, 1-2 regions($45)	**YES**	**NO**
CPT Code 98941: Chiropractic manipulative treatment (CMT); Spinal, 3-4 regions ($50)	**YES**	**NO**
CPT Code 98942: Chiropractic manipulative treatment (CMT); Spinal, 5 regions ($60)	**YES**	**NO**
MASSAGE THERAPY:		
CPT Code 97124: Massage therapy (1 Hour = 4 units $80 / 30 Min = 2 units $45)	**YES**	**NO**

*Due to insurance company time filing constraints, ECC will **FILE** insurance claims for massage therapy but will no longer be filing pre-authorizations, treatment notes, plans of treatment, etc. with any insurance company.*

Pediatric Patient Questionnaire

Confidential Patient Information

Child's Name: | Parent/Guardian Name(s):

Street Address: | City, State, Postal Code:

Cell Phone: | Other Phone: | Child's Sex:

Email: | Child's SSN: | Birthdate: | Age:

How did you hear about us? | Height: | Weight:

Who is your primary care physician?

Is your child receiving care from any other health professionals? ○ Yes ○ No
– If yes, please name them and their specialty:

Please list any drugs/medications/vitamins/herbs or other that your child is taking:

Current Health Conditions

What health condition(s) bring your child to be evaluated by a chiropractor?

When did the condition first begin? | How did the problem start? ○ Suddenly ○ Gradually ○ Post-Injury

Has your child ever received care for this condition? ○ Yes ○ No
– If yes, please explain:

Is this condition: ○ Getting worse ○ Improving ○ Intermittent ○ Constant ○ Unsure

What makes the problem better? | What makes the problem worse?

Health Goals for Your Child

What are your top three health goals for your child?

1. _____
2. _____
3. _____

What would you like to gain?

○ Resolve existing condition
○ Overall wellness
○ Both

Has your child ever visited a chiropractor? ○ Yes ○ No – If yes, what is their name:

– What is their specialty: ○ Pain Relief ○ Physical Therapy & Rehab ○ Nutrition ○ Subluxation-based ○ Other:

Pregnancy & Fertility History

Please tell us about your pregnancy:

Any fertility issues? ○ Yes ○ No If yes, please explain: _____

Did mother smoke? ○ Yes ○ No If yes, how often? _____

Did mother drink? ○ Yes ○ No If yes, how often? _____

Did mother exercise? ○ Yes ○ No If yes, please explain: _____

Was mother ill? ○ Yes ○ No If yes, please explain: _____

Any ultrasounds? ○ Yes ○ No If yes, please explain: _____

Please explain any noticable episodes of mental or physical stress during your pregnancy:

Please explain any other concerns or notable remarks about your child's conception or pregnancy:

Labor & Delivery History

Child's birth was: ◯ Natural vaginal birth ◯ Scheduled C-section ◯ Emergency C-section – At how many weeks was your child born?

Where was your child born? – Who delivered your baby?

Please indicate any applicable interventions or complications:
◯ Breech ◯ Induction ◯ Pain meds ◯ Epidural ◯ Episiotomy ◯ Vacuum extraction ◯ Forceps ◯ Other:

Please describe any other concerns or notable remarks about your child's labor and/or delivery:

Child's birth weight: Child's birth height: APGAR score at birth: APGAR score after 5 min.:

Growth & Development History

Is/was your child breastfed? ◯ Yes ◯ No – If yes, how long? Difficulty with breastfeeding? ◯ Yes ◯ No

Did they ever use formula? ◯ Yes ◯ No – If yes, at what age? – If yes, what type?

Did/does your child suffer from colic, reflux, or constipation as an infant? ◯ Yes ◯ No
– If yes, please explain:

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? ◯ Yes ◯ No
– If yes, please explain:

At what age did the child: Respond to sound:_____ Follow an object:_____ Hold their head up:_____ Vocalize:_____
Teethe:_____ Sit alone:_____ Crawl:_____ Walk:_____ Begin cow's milk:_____ Begin solid foods:_____

Please list any food intolerance or allergies, and when they began:

Please list your child's hospitalization and surgical history (including the year):

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime (including the year):

Have you chosen to vaccinate your child? ◯ No ◯ Yes, on a delayed or selective schedule ◯ Yes, on schedule
– If yes, please list any vaccine reactions:

Has your child received any antibiotics? ◯ Yes ◯ No
– If yes, how many times and list reason:

Night terrors or difficulty sleeping? ◯ Yes ◯ No – If yes, please explain:

Behavioral, social or emotional issues? ◯ Yes ◯ No – If yes, please explain:

How many hours per day does your child typically spend watching TV, computer, tablet or phone?

How would you describe your child's diet? ◯ Mostly whole, organic foods ◯ Pretty average ◯ High amount of processed foods

Acknowledgement & Consent

Parent/Guardian Signature: _____ Date: _____

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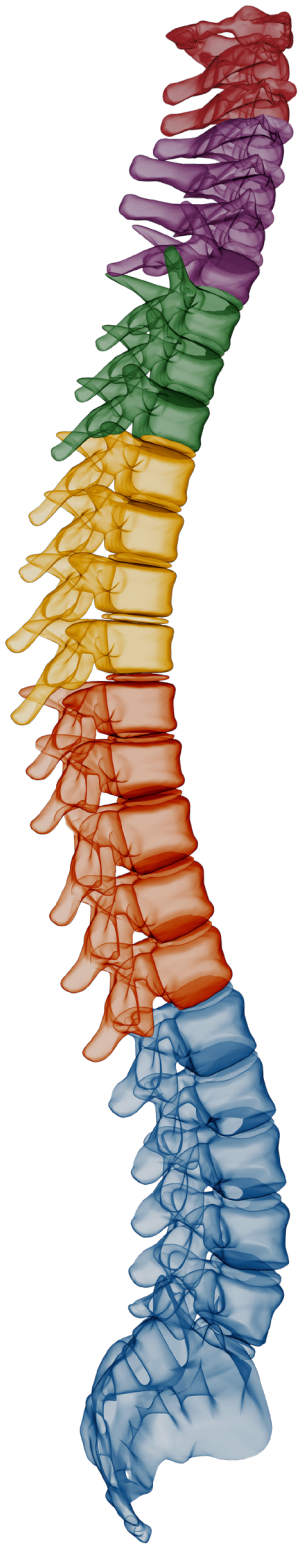
Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



Cervical

Functions

- Autonomic Nervous System
- ENT System
- Vision, Balance & Coordination
- Speech
- Immune System
- Digestive System
- Nerve Supply to Shoulders, Arms & Hands
- Sympathetic Nucleus
- Metabolism

Symptoms

PAST	PRESENT		PAST	PRESENT	
☐	☐	Colic & Excessive Crying	☐	☐	Epilepsy & Seizures
☐	☐	Ear & Sinus Infections	☐	☐	Sensory & Spectrum
☐	☐	Allergies & Congestion	☐	☐	ADD / ADHD
☐	☐	Immune Deficiency	☐	☐	Focus & Memory Issues
☐	☐	Headaches & Migraines	☐	☐	Anxiety & Stress
☐	☐	Vertigo & Dizziness	☐	☐	Balance & Coordination
☐	☐	Sore Throat & Strep	☐	☐	Speech Issues
☐	☐	Swollen Tonsils & Adenoids	☐	☐	TMJ / Jaw Pain
☐	☐	Vision & Hearing Issues	☐	☐	Stiff Neck & Shoulders
☐	☐	Low Energy & Fatigue	☐	☐	Depression
☐	☐	Difficulty Sleeping	☐	☐	High Blood Pressure
☐	☐	Pain, Numbness & Tingling in Arms to Hands	☐	☐	Poor Metabolism & Weight Control

Upper Thoracic

Functions

- Upper G.I.
- Respiratory System
- Cardiac Function

Symptoms

☐	☐	Reflux / GERD	☐	☐	Bronchitis & Pneumonia
☐	☐	Chronic Colds & Cough	☐	☐	Functional Heart Conditions
☐	☐	Asthma			

Mid Thoracic

Functions

- Major Digestive Center
- Detox & Immunity

Symptoms

☐	☐	Gallbladder Pain / Issues	☐	☐	Indigestion & Heartburn
☐	☐	Jaundice	☐	☐	Stomach Pains & Ulcers
☐	☐	Fever	☐	☐	Blood Sugar Problems

Lower Thoracic

Functions

- Stress Response
- Filtration & Elimination
- Gut & Digestion
- Hormonal Control

Symptoms

☐	☐	Behavior Issues	☐	☐	Allergies & Eczema
☐	☐	Hyperactivity	☐	☐	Skin Conditions / Rash
☐	☐	Chronic Fatigue	☐	☐	Kidney Problems
☐	☐	Chronic Stress	☐	☐	Gas Pain & Bloating

Lumbar, Sacrum & Pelvis

Functions

- Lower G.I. (Absorption & Motility)
- Gut-Immune System
- Major Hormonal Control

Symptoms

☐	☐	Constipation	☐	☐	Sciatica & Radiating Pain
☐	☐	Chrohn's, Colitis & IBS	☐	☐	Lumbopelvic / SI Joint Pain
☐	☐	Diarrhea	☐	☐	Hamstring Tightness
☐	☐	Bed-wetting	☐	☐	Disc Degeneration
☐	☐	Bladder & Urination Issues	☐	☐	Leg Weakness & Cramps
☐	☐	Cramps & Menstrual Issues	☐	☐	Poor Circulation & Cold Feet
☐	☐	Cysts & Endometriosis	☐	☐	Knee, Ankle & Foot Pain
☐	☐	Infertility	☐	☐	Weak Ankles & Arches
☐	☐	Impotency	☐	☐	Lower Back Pain
☐	☐	Hemorrhoids	☐	☐	Gluten & Casein Intolerance

Patient Name: _____ Date: _____

HIPAA Compliance *Patient Consent Form*

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. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice, please sign and return to our front desk receptionist.

PERMITTED DISCLOSURES:

1. Treatment purposes – discussion with other health care providers involved in your care.
2. Inadvertent disclosures – open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so 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 eminent threat to the health or safety of a person or 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 – discussion 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 a missed appointment or apprize 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 receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please contact our office. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights 200 Independence Ave. SW Room 509F HHH Building Washington DC 20201

I have received a copy of Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at an time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me. At this time, I do not have any questions regarding my rights or any of the information I have received.

May we discuss your medical condition with any member of your family? ◯Yes ◯No

If yes, please name family members allowed: _____

This consent was signed by: _____ Signature: _____ Date: _____

Emergency Contact: _____ Phone Number: _____

Informed Consent for Chiropractic Care

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE THIS OFFICE TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

Patient Name: _____ Signature: _____ Date: _____

Guardian Signature (for minor): _____ Relationship to Patient: _____

☐ In addition, I give my permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

DATE: _____ Account: _____ Doctor:_____

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Financial Policy

It is the policy of Edgewood Chiropractic Center that all services rendered are charged directly to you, the patient, and that ultimately the patient is responsible for all services, including those not reimbursed by your insurance or third-party payer. All Payments are due at the time of service, unless prior arrangements have been made. Our office accepts assignment with most insurance companies; however, **insurance is not a guarantee of payment**. Your insurance is an agreement between you and your insurance company. All insurance patients must pay their deductibles in full and copayments/coinsurance at time of service. If our office has not received payment by your insurance company within forty-five (45) days of our office submitting the claim, you will become responsible for payment in full. I, the undersigned, do hereby agree to be financially responsible for the entire balance due, including, but not limited to examinations, consultations, and/or treatments. I also acknowledge there will be a $35.00 fee for any checks returned due to insufficient funds. I understand that this service fee maybe in addition to any fees assessed by my financial institution. Furthermore, I agree that a late charge of 1.5% per month maybe assessed on any balance more than 30 days delinquent. In the event of any default in payment, I agree to pay all attorney fees and/or other collection costs necessary to collect on my delinquent account.

_____
Printed Name of Patient

X_____ _____
Signature of Patient Date

X_____ _____
Signature of Representative (If patient is minor / POA) Date

X_____ _____
Witness to Patient Signature Date

	PRIMARY HEALTH INSURANCE	SECONDARY HEALTH INSURANCE
Insurance Carrier Name		
Subscriber's Name		
Subscriber's Date of Birth		
Subscriber's Employer		
Policy / ID Number		
Group Number		

DATE: _____ Account: _____ Doctor:_____

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Massage Therapy Policy

_____ *(please initial)* **SCHEDULING**

Due to the increased demand for massages and our limited space for our massage therapist we need to limit the frequency of massages to one per month. We will allow patients to schedule one massage per month no sooner than two months ahead. This will give every patient an opportunity to have a convenient time that will best suit his/her schedule.

_____ *(please initial)* **CANCELLATIONS**

We understand that situations arise in which you must cancel your massage appointment. It is therefore requested that if you must cancel your appointment, you provide at least 24-hour notice. This enables another patient who is waiting for a massage appointment to be scheduled in that appointment time. With cancellations made less than 24 hours prior, we are unable to offer that time to other patients.

We understand that certain unavoidable circumstances may not allow you to cancel with 24 hours. You may be subject to a $40.00 late cancellation fee in this instance. Late cancellation fees may be waived with approval of management only. ECC believes that a good massage therapist / patient relationship is based upon understanding and good communication.

_____ *(please initial)* **NO SHOW FEE**

Patients who do not show for his/her massage appointment will be charged a $40.00 No Show Fee. There is no exception to this fee. No show charges are the sole responsibility of the patient and cannot be billed to insurance. Any fees must be paid in full prior to the patients next appointment.

_____ *(please initial)* **MINOR POLICY**

Completion of this form by a parent or guardian confirms consent for patients eighteen (18) and under to receive massage at Edgewood Chiropractic Center.

PLEASE SIGN AFTER YOU AGREE TO THE FOLLOWING:

- Edgewood Chiropractic Center Massage Therapy Scheduling Policy
- Edgewood Chiropractic Center Cancellation Policy
- Edgewood Chiropractic Center No Show Fee Policy
- Edgewood Chiropractic Center Minor Policy

_____
Printed Name of Patient

X_____ _____
Signature of Patient Date

X_____ _____
Signature of Representative (If patient is minor / POA) Date

X_____ _____
Witness to Patient Signature Date