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SPINAL OPTIMIZATION

PATIENT INFORMATION

Full Name:_____**Today's Date:**_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Email:_____ SS#:_____

Date of Birth:_____ Sex: M / F Height:___ft___in Weight:_____ Ethnicity:_____

Current Address:_____

City:_____State:_____Zip:_____

EMERGENCY CONTACT / LEGAL GUARDIAN

[] If the patient is a MINOR.

Name:_____ Phone:_____

Relationship to patient:_____Date of Birth:_____

WORK INFORMATION

Employer:_____ Occupation:_____

Work Address:_____

City:_____State:_____Zip:_____

INSURANCE INFORMATION

Health Insurance? Y / N **** If yes, please ensure we have a copy of your insurance card.***

[] Blue Cross / Care First [] Aetna [] Cigna [] United HealthCare [] Medicare [] Other:_____

Policy Holder's Name: _____ Date of Birth: _____

Is your condition the result of a work or automobile accident? Y / N

**** If yes, please complete the information below.***

Auto Insurance or Workers Comp Company: _____

Policy #:_____ Claim #:_____

Adjuster's Name: _____Adjuster's Phone #: _____

Lawyer's Name: _____ Lawyers Phone #:_____

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REVIEW OF SYSTEMS

GENERAL & MUSCULOSKELETAL:
[] Recent Weight Gain/Loss
[] Loss of Balance
[] Weakness
[] Fatigue
[] Fever
[] Fainting Spells
[] Nausea
[] Vomiting
[] Balance Problems
[] Jaw Pain
[] Neck Pain
[] Neck Stiffness
[] Shoulder Pain
[] Arm Pain
[] Wrist/Hand Pain
[] Numbness Arms/Hands
[] Upper Back Pain
[] Lower Back Pain
[] Hip Pain
[] Leg Pain
[] Ankle/Foot Pain
[] Numbness Legs/Feet
[] Join Swelling
[] Tension
[] Nervousness
[] Anxiety
[] Irritability
[] Sleeping Problems
[] Depression
[] Liver Problems
[] Cancer

HEAD:
[] Headaches
[] Loss of Consciousness
[] Dizziness
[] Memory Problems
[] Seizures/Convulsions

EYES:
[] Wear Eye Glasses/Contacts
[] Double Vision
[] Blurred Vision
[] Loss of Vision
[] Eyes Sensitive to Light

EARS:
[] Loss of Hearing
[] Ringing/Buzzing in Ears
[] Ear Infections
[] Vertigo/Dizziness
[] Discharge from Ears

NOSE:
[] Sinus Problems
[] Nose Bleeds/Epitaxis
[] Loss of Smell
[] Discharge from Nose

MOUTH / THROAT:
[] Tooth Pain
[] Sores in Mouth / Lips
[] Frequent Sore Throats
[] Difficulty Swallowing
[] Thyroid Problems

RESPIRATORY / LUNGS:
[] Difficulty Breathing
[] Chronic Cough
[] Asthma
[] Bronchitis
[] Emphysema
[] Tuberculosis / Pneumonia

CARDIOVASCULAR / HEART:
[] Chest Pain
[] Shortness of Breath
[] Palpitations
[] Night Sweats
[] Cold Extremities
[] High Blood Pressure
[] Low Blood Pressure
[] Heart Murmurs

GENITOURINARY / FEMALES:
[] Urinary Tract Infections
[] Breast Cancer/Tumors
[] Blood in Urine
[] Painful Urination
[] Vaginal Discharge
[] PMS
[] Loss of Bladder Control
[] Use Birth Control Pills

GENITOURINARY / MALES:
[] Prostate Problems
[] Hernias
[] Penile Discharge
[] Blood in Urine
[] Painful Urination
[] Frequent Urination
[] Testicular Pain
[] Loss of Bladder Control

ENDOCRINE:
[] Cold / Heat Intolerance
[] Excessive Sweating
[] Excessive Thirst / Hunger
[] Diabetes
[] Thyroid Problems
[] Kidney Problems

GASTROINTESTINAL:
[] Abdominal Pain
[] Upset Stomach
[] Loss of Appetite
[] Indigestion
[] Constipation
[] Diarrhea
[] Bloody Stool
[] Excessive Gas
[] Loss of Bowel Control

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HISTORY OF PRESENT ILLNESS

How can we help you? (briefly describe in words)_____

_____

When did your problem begin (a specific date if possible)_____

_____

Have you ever had this problem before? Y / N If YES, please describe:_____

_____

Is this problem: (circle all that apply) Job Related Sports Related Auto Accident Home Injury

Occurred without Trauma Result of Surgery Other:_____

What makes your problem BETTER? (circle all that apply)

Lying Down Sitting Standing Walking General Exercise Inactivity Nothing

Hot Cold Massage Certain Positions:_____ Something Else:_____

What makes your problem WORSE? (circle all that apply)

Lying Down Sitting Standing Walking General Exercise Inactivity Nothing

Hot Cold Massage Certain Positions:_____ Something Else:_____

Does your pain radiate or travel from one area to another? [] Y [] N

If YES, please describe:_____

How often are the complaints present? (circle) Constantly! (76-100%) Frequent (51-75%)

Occasional (26-50%) Intermittent (25% or less)

Since the problem began, the pain has: (circle one) Increased Decreased

Not Changed Disrupted Sleep Been Constant Fluctuated

Please list other health concerns you want addressed: []N/A

1)_____ 2)_____

3)_____ 4)_____

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I am currently in pain while I fill this form out: Y / N

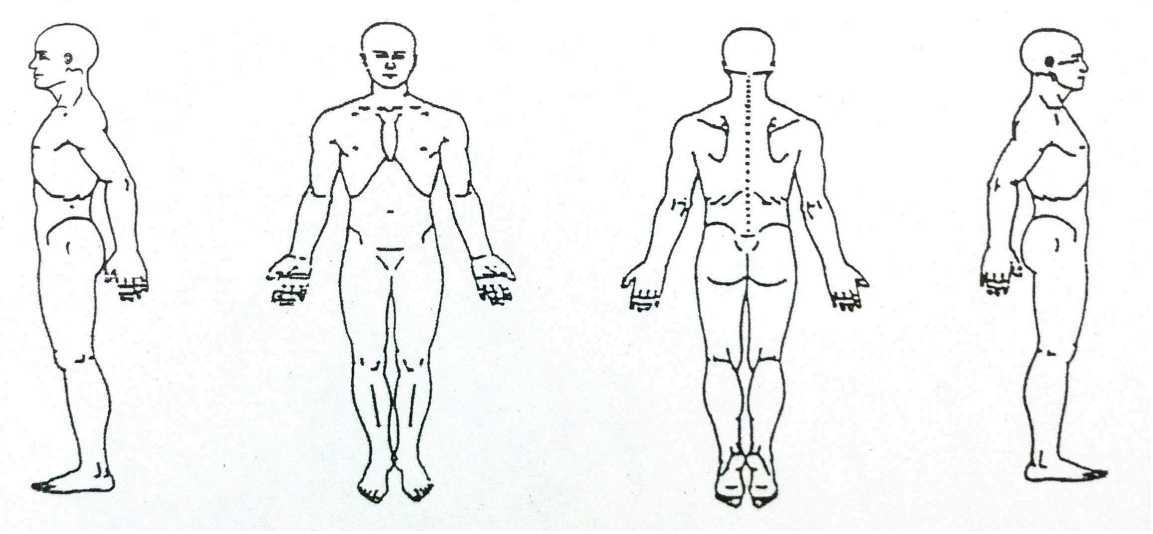
NO PAIN<----------> Worst Pain EVER

1 2 3 4 5 6 7 8 9 10

Please locate and mark the quality of your pain on the drawings:

A=Ache B=Burning N=Numb P=Pins & Needles S=Stabbing

X=Other:_____



(use the corresponding letters or any other markings/descriptions you like)

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PAST MEDICAL HISTORY

Who is your primary care physician?_____

[] I don't know / I can't remember [] I don't have one!

Where and when did you last receive health care?_____

Date of last physical: (approx.)_____ [] Never had one before [] I don't know / I can't remember

Date of last blood test: (approx.)_____ [] Never had one before [] I don't know / I can't remember

Date of last X-ray/MRI: (approx.)_____ [] Never had one before [] I don't know / I can't remember

Have you been tested HIV positive? Y / N

Please list any **serious trauma** you have had in your lifetime, such as a car accident or fall:

_____[]N/A

Please list any **major surgeries** or hospitalizations you have had in your lifetime:

_____[]N/A

Please list any food, drug, or substance **allergies or adverse reactions** you're aware of:

_____[]N/A

Please list any current **medical conditions** you're dealing with:

_____[]N/A

Please list any **medications/pills** you are currently taking:

_____[]N/A

WOMEN ONLY: Date of last menstrual period: _____ [] Menopause

Are you pregnant right now? [] YES [] NO [] NOT SURE

WOMEN ONLY: # of Pregnancies:_____ # Live Births:_____

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FAMILY HISTORY & SOCIAL HISTORY

You are: [] married []divorced []separated []single []re-married [] have a partner
[] widowed []engaged

To the <u>best of your knowledge</u>, has your mother, father, siblings, or grandparents ever had any of the following? [ ] Adopted [] Don't Know

High Cholesterol Thyroid Disease Osteoporosis Mental Anxiety/Panic Attacks

Asthma Eczema Allergies Arthritis Heart Disease/Hypertention Stroke

Depression Ulcerative Colitis Crohn's Autoimmune disease Alzheimer's Alcoholism

Kidney Disease Cancer Diabetes Obesity

How would you rate your over all stress level? (circle)

No stress Minimal Moderate Greatly

How would you rate your physical activity at work? (circle)

Sit 75%+ of Work-day Up and About at Work Light Labor Moderate Labor Heavy Labor

How would you rate your over exercise (planned activity) level? (circle)

None! Light Moderate Heavy Professional

Please describe your intake of the following:

Fruits/Vegetables:_____Meats:_____

Coffee:_____Alcohol:_____

Cigarettes:_____Sugar/Corn Syrups:_____

Wheat:_____Dairy:_____

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OPTIONAL:

What is your long-term goal upon completion of treatment? (ie: return to horseback riding, etc)

_____

_____

The doctor generally discusses supportive dietary and nutritional recommendations that best support your goals and needs. Please rate your interest in the following:

Weight Loss:	0	1	2	3	4	5
Anti-Inflammation:	0	1	2	3	4	5
Organ Detoxification:	0	1	2	3	4	5

Please list any hobbies, talents, or interests you may have:_____

What was the last book you finished reading?_____

If so, where did you attend college?_____

YOUR SIGNATURE:_____DATE:_____

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HIPAA: Protecting Your Health Information

Regulation Passed

The Health Insurance Portability and Accountability Act or HIPAA does three primary things:

1. It helps standardize and simplify the way health care organizations exchange health care data;
2. It provides consumers with additional protections for getting and maintaining health insurance coverage, although, it does not guarantee coverage;
3. It creates new security rules to ensure the safety and privacy of individual and medical records.

Our pledge regarding medical information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record for the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. In addition, we have a policy in effect that makes every attempt to maintain the confidentiality of all patient's information.

Disclosure of Medical Information

In addition to disclosing your medical information for treatment, payment and health care operation, we may disclose medical information for the following purposes: court order, subpoena, discovery request, or other lawful process. We may disclose medical information to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose health information when authorized and necessary to comply with laws relating to worker's compensation, auto accidents, personal injury or other similar issues.

If someone calls or comes by, they will be given general information about your care and/or appointments unless otherwise specified and noted in your file. We will also be publicly noting your name in our newsletter and/or picture in our lobby unless otherwise specified. Also upon becoming a patient, we will be entering your name into our database and you will receive our monthly newsletter. If you do not wish to receive our newsletters, please contact our office and advise the receptionist of such. This list will not be sold to any outside agencies.

Your Rights

You have the right to look at or get copies of your medical records and to receive a list of all the times we shared your medical information for purposed other than treatment, payment and health care operations.

Open Adjustment Concept

Because of the open adjustment concept in this office, it is possible for doctor/patient discussions to be overheard by other patients. Most discussions will involve spinal health, but may also include anything concerning the primary health care of that patient. If you prefer to have your interaction with the doctor in a completely private setting, please just ask the doctor.

Notification by Mail or Phone

Patients may be contacted by mail or phone unless written notification is requested that contact be only in person.

Complaints

If you feel that your rights have been violated, contact the Office Manager or the U.S. Department and Human Services.

* This is your copy to keep for your records *

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Dear Patient,

Our financial policy is to be transparent up front. Our out-of-pocket cost for all services is available online at www.drkoloski.com along with packaged discounts. When using your health insurance in conjunction with our Spinal Optimization System treatment plan, we will review what is covered and what is not, prior to starting.

FINANCIAL POLICY:

1) We are not debt collectors. Financial arrangements guaranteeing payments must be in place prior to beginning your care.
2) We did not choose or purchase your health insurance plan. We will honor it if you choose to assign your insurance benefits to us. Please read your insurance policy to understand its coverage.
3) All sales for rendered services are final.
4) Refunds for pre-paid or packaged services (treatment not yet rendered) are reimbursable according to the full fee schedule (no discounts). Refunds will be processed via bank check to avoid double merchant processing fees (2.5% to process, 2.5% to refund).
5) All sales for supplements are final, *unless*:
    a. They are un-opened with the original seal intact *and*
    b. They are returned with-in one week of the date of sale.
6) Sales of expired products sold at a discount are final.
7) Refunds for services rendered that are covered and processed by an insurance company are NEVER allowed (violates law).
8) Treatment cost estimates of coinsurance payments and "allowed" or "covered" services by your insurance are exactly that: estimates.
    a. Please understand our best efforts, expertise and experience are used; however, *the exact explanation of benefits will be mailed by your insurance company, to both parties, after our submission and their processing of the claim*.
9) Automatic & Guaranteed Payment:
    a. Your credit card will be securely stored in our merchant vault and used to process co-pays and any other fees at time-of-service.
    b. Upon receipt of your insurance company's explanation of benefits, your credit card will be used for any outstanding financial insurance responsibility that remains.
    c. You will be contacted to make aware of your balance and we will use your previous approval to charge your card accordingly.
10) Our system will automatically generate an email confirmation for any sale and send it to your email address on file.
11) There will be a fee assessed for any payments by check that are returned from our bank equal to our bank fees. If checks are consistently returned we may deny you that form of payment.
12) For questions regarding a balance, email: Manager@DrKoloski.com
13) Undisputed balances beyond net-90 days will be sent to collections.

Initial: _____

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Terms of Acceptance

The goal of our office 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 the below information and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic physician provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by Dr. Koloski Chiropractic, LLC, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Communications:

In the event we need to communicate your health care information, to whom may we do so?

Spouse:_____

Children:_____

Other:_____

May we: send reminder cards, leave phone messages, and emails? [ ] Yes [ ] No

I, _____, have read and fully understand the above statements.

Acknowledgement

I have received the notice of privacy practices (HIPAA) and have been provided the opportunity to discuss my right to privacy.

Print Name:_____

Signature:_____ Date:_____

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Legal Assignment of Benefits and Release of Healthcare and Plan Documents

Insurance/Attorney/Employee Health Care Plan: _____

In considering the amount of healthcare expenses to be incurred, I, the undersigned, have insurance and/or employee healthcare benefits coverage with the above captioned, and hereby assign and convey directly to **Dr. Koloski Chiropractic, LLC/Dr. John Koloski** (The Practice) all health care benefits and/or insurance reimbursement, and/or case settlement, if an, otherwise payable to The Practice for services rendered for such doctor and practice. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all healthcare information necessary to process this claim. I hereby authorize any plan administrator or fiduciary insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor or clinic in order to claim such healthcare benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee benefits claims submissions.

I hereby convey to The Practice to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plans any claim, chose in action, or other right I may have to such insurance and/or employee healthcare benefits coverage under any applicable insurance policies and/or employee healthcare plan with respect to health care expenses incurred as a result of the healthcare service I received from The Practice to the extent permissible under the law to claim such benefits, insurance reimbursement and any applicable remedies.

Further, in response to any reasonable request for cooperation, I agree to cooperate with The Practice in any attempts by such doctor and clinic to pursue such claim, chose in action or right against any insurers and/or employee health care plan, including, if necessary, bring The Practice against such insurers and/or employee health care plan in my name by at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signature: _____ Date: _____

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Doctor / Hospital: _____

Address: _____

_____

_____

I hereby authorize and request the release of my medical records to:

Dr. Koloski Chiropractic, LLC
2024 West Street, Suite #202
Annapolis, MD 21401

Thank you in advance for your cooperation.

_____ _____
Patient's Signature Date

_____
Patient's Name (Please Print)

_____ _____
If Patient is a minor, signature of Parent or Legal Guardian Relationship to Patient

_____
Witness to the Above Signatures

_____
Witness' Name (Please Print)

Phone: 240.439.9764 Fax: 443.782.3490