Welt Chiropractic Center

Referred by: *_____

Name: *_____

Address*_____ City*_____ State* _____ Zip Code *_____

Cell Phone *_____ H. Phone_____ W. Phone _____

Email Address: *_____

Date of Birth:*_____ Age: *____ Sex: * ____ Height: *_____ Weight: *_____

Employer*_____ Occupation*_____

Marital Status: * M S D W No. of Children: * ____ Boys/Ages: *_____ Girls/Ages: *_____

Spouse's/Partner's Employer: _____ Spouse's/Partner's Occupation: _____

Contact Person in Emergency: *_____ Phone#: *_____

Have you ever received Chiropractic Care? * Yes No If yes, when? _____

Name of most recent Chiropractor: * _____

Is Today's visit due to Auto Injury or Worker's Comp? * Yes No Signature: *_____

1. Reasons for seeking Chiropractic care:

Primary reason: *_____

Secondary reason: *_____

2. Previous interventions, treatments, medications, surgery, or care you've received for your complaint(s):

*_____

_____

3. Past Health History: *

A. Please indicate if you have a history of any of the following:

□ Cancer □ Diabetes □ Psychiatric disorders
□ Bipolar disorder □ Major depression □ Schizophrenia
□ Stroke/TIA's □ Anticoagulant use □ Bleeding problems
□ Heart problems/high blood pressure/chest pain □ Lung problems/shortness of breath
□ Other _____ □ None of the above

B. Previous Injury or Trauma: *_____

_____

_____

C. Have you ever broken any bones? Which? *_____

_____

D. Allergies: *_____

E. Medications: (Provide list if needed) **

Medication * **Reason for taking***

_____
_____
_____
_____

C. Surgeries: *

Date* Type of Surgery*

_____
_____

4. Family Health History: *

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease
□ Neurological diseases □ Adopted/Unknown □ Cardiac disease below age 40
□ Psychiatric disease □ Diabetes
□ Other _____ □ None of the above

Deaths in immediate family: _____

Cause of parents or siblings death Age at death

_____
_____
_____

Social and Occupational History: *

A. Job description: *
_____
B. Work schedule:
_____
C. Recreational activities: *
_____
D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): *
_____

_____

Review of Systems*

Have you had any of the following pulmonary (lung-related) issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other_____ □ None of the above

Have you had any of the following cardiovascular (heart-related) issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs
□ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain
□ Irregular heartbeat □ Other_____ □ None of the above

Have you had any of the following neurological (nerve-related) issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ Loss of sense of smell
□ Headaches □ Memory loss □ Tremors □ Vertigo
□ Strokes/TIAs □ One-sided decreased feeling in the face or body
□ Other_____ □ None of the above

Have you had any of the following endocrine (glandular/hormonal) related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements
□ Diabetes □ Other _____ □ None of the above

Have you had any of the following renal (kidney-related) issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis
□ Other _____ □ None of the above

Have you had any of the following gastroenterological (stomach-related) issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain
□ Hiatal hernia □ Bloody or black tarry stools □ Pancreatic disease □ Irritable bowel/colitis
□ Vomiting blood □ Bowel incontinence □ Constipation □ Hepatitis or liver disease
□ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following hematological (blood-related) issues?
□ Anemia □ Abnormal bleeding/bruising □ Sickle-cell anemia □ Anticoagulant therapy
□ Enlarged lymph nodes □ Hemophilia □ HIV positive □ Regular aspirin use
□ Hyper coagulation or deep venous thrombosis/history of blood clots
□ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve)
□ Other _____ □ None of the above

Have you had any of the following dermatological (skin-related) issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders
□ Other _____ □ None of the above

Have you had any of the following musculoskeletal (bone/muscle-related) issues?
□ Rheumatoid arthritis □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery
□ Joint surgery □ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Gout
□ Other _____ □ None of the above

Have you had any of the following psychological issues?
□ Psychiatric diagnosis □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations
□ Schizophrenia □ Depression □ Psychiatric hospitalizations
□ Other _____ □ None of the above

Symptom Questioner (EXAMPLE: Headaches, R Neck Pain, Low Back Pain)

Symptom 1* _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- When did the symptom begin? _____
  - o Did the symptom begin suddenly or gradually? (circle one)
  - o How did the symptom begin? _____

- What makes the symptom worse? **(circle all that apply)**:
  - o Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing,
  - Other (please describe): _____

- What makes the symptom better? (circle all that apply):
  - o Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing,
  - Other (please describe): _____

- Describe the quality of the symptom (circle all that apply):
  - o Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging,
  - Other (please describe): _____

- Does the symptom radiate to another part of your body (circle one): yes no
  - o If yes, where does the symptom radiate? _____

- Is the symptom worse at certain times of the day or night? (circle one)
  - o Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- When did the symptom begin? _____
  - o Did the symptom begin suddenly or gradually? (circle one)
  - o How did the symptom begin? _____

- What makes the symptom worse? (**circle all that apply**):
  - o Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing,
    Other (please describe): _____

- What makes the symptom better? (circle all that apply):
  - o Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing,
    Other (please describe): _____

- Describe the quality of the symptom (circle all that apply):
  - o Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging,
    Other (please describe): _____

- Does the symptom radiate to another part of your body (circle one): yes no
  - o If yes, where does the symptom radiate? _____

- Is the symptom worse at certain times of the day or night? (circle one)
  - o Morning Afternoon Evening Night Unaffected by time of day

Is there anything else in your past medical history that you feel is important to your care here?

_____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Welt Chiropractic PC. for services performed.

Patient or Guardian Signature: *_____Date:*_____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

*_____ *_____

Signature of Patient or Representative Date

*_____

Printed Name

INFORMED CONSENT

Every type of health care is associated with some risk of a potential problem. This includes Physical Therapy care. We want you to be informed about potential problems associated with Physical Therapy care before consenting to treatment. In this office, we use trained personnel to assist the doctor with portions of your consultation, examination, physical therapy application, traction, massage therapy, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor will treat you on that day.

Stroke: Stroke is the most serious problem associated with any therapy. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain with a very rare complication of death. Manipulation have been associated with strokes that arise from the vertebral artery only, this is because the vertebral artery is actually found inside the neck vertebrae. The manipulation that is related to vertebral artery stroke is called the "extension-rotation-trust atlas adjustment". We do not do this type of manipulation on our patients. Other types of neck manipulation may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA, Vol.37 No.2, June 1993) estimates that the incident of this type of stroke is 1 per every 3,000,000 upper neck manipulation. This means that an average therapist would have to be in practice for hundreds of years before they would statistically be associated with a single stroke patient.

Disc Herniation: Disc herniation that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by manipulation, traction, etc. This includes both in the neck and back. Yet, occasionally manipulative treatment (adjustment, traction, etc.) will aggravate the problem and rarely surgery may become necessary for correction. Rarely manipulative treatment may cause a disc problem if this disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissue primarily refers to muscle and ligaments. Muscle moves bone and ligaments limit joint movement. Rarely mobilization, traction, massages therapy, etc. may tear some muscle ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantity their probability.

Soreness: It is common for resistance exercise, traction, massage therapy, etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

Other Problems: There may be other problems or complications that might arise from physical therapy treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery and therefore as with any health care delivery system we cannot promise a cure from any symptoms, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider whom we feel will assist your situation.

If you have any questions on the above please ask your doctor. I hereby authorize Welt Chiropractic PC. Clinicians and the staff to perform physical therapy treatment and physiological therapeutics on m.

*_____ *_____

Patient's Name (Printed) Today's Date

*_____ *_____

Patient's Signature Parent or Guardian Signature for Minor

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: *_____ DOB: *_____

Information Requested: Diagnostic Reports [X-ray; CT; MRI; Bone Scan; NCV; EMG]

Emergency Room Records

Other: _____

_____

_____

This authorization shall become effective immediately and remain effective only as long as necessary for the request to complete the required activities undertaken.

I understand I have a right to receive a copy of this authorization upon my request!

Signature of patient: *_____

Signature of Spouse / Guardian: *_____

Date of Request: _____

Records are being requested from: Welt Chiropractic PC.

74 Taunton St Ste. 102

Plainville, MA. 02762

Phone: 508-643-0106 Fax: 508-643-0107

Please send records via: [MAIL FAX] with attention to:
Dr. Hubert V Welt

Welt Chiropractic Center
74 Taunton St Ste. 102
Plainville, MA. 02762
Phone: 508-643-0106 Fax: 508-643-0107

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NOTICE OF IRREVOCABLE LIEN AND ASSIGNMENT OF BENEFITS AUTHORIZATION FOR RELEASE OF TREATMENT RECORDS

PROVIDER'S LEGAL & EQUITABLE LIEN

Name of Practice: ***Welt Chiropractic PC***. Provider: ***Hubert Welt DC, DACO***

Patient Name:*_____ Address:_____

City:_____ State:_____ Zip:_____

In consideration of the agreement of the Provider named above to provide me with injury treatment services, I hereby to the extent of my treatment bills irrevocably assign to my Provider all my right, title and interest to and in all applicable insurance and indemnification reimbursement benefits of applicable insurance companies including but not limited to: automobile PIP (Personal Injury Protection) coverage; Medical Payment Coverage and health care coverage (major medical, medicare, private insurance or any other health plans) to which I may be entitled to pay my Provider for services rendered to treat me on and after the above date in connection with my injury or illness.

I further grant to my Provider an irrevocable Equitable Lien and an Official Legal Lien as set forth in Ch111§70A through Ch111§70D Mass. General Laws to and in any insurance benefits that may be due me and I furthermore authorize my Provider to provide my attorney and any applicable insurance companies involved with a full report concerning my condition and treatment, including but not limited to office notes, dates of visits, and charges incurred.

I hereby authorize and direct any and all applicable insurance companies to make immediate payment directly to my said Provider for all benefits and sums due me that may be due him or her upon receipt by you of my Provider's itemized statement for treatment services rendered to me.

It is further agreed that payment by any insurance company involved as herein directed to my Provider of any itemized statement shall be considered the same as if paid by the insurer directly to me.

I am aware that I remain personally responsible to my Provider for the full amount of my unpaid treatment bills and further direct any Attorney representing me to withhold from the proceeds upon any final settlement or final disposition of my case an amount equal to that to pay any outstanding unpaid balance of my bills. This includes any balance due as a result of an independent medical exam that discontinued my medical payments benefit.

Patients Signature: *_____ Date: *_____

Parent/Guardian Signature: *_____ Date: *_____

A photocopy of this form can be accepted with the same authority as the original.

FINANCIAL POLICIES

As a courtesy not mandatory to our patients, we will make attempts to verify your insurance coverage. Our office do NOT sell or negotiate insurance coverage from the company you purchased your insurance policy. You are responsible for knowing your coverage on the services (Chiropractic therapy) we provide. We do allow other payment options within the guidelines of the policy.

SELF PAY: We accept Cash, Check, Visa, MasterCard, and Discover.

COMMERCIAL INSURANCE: Patients are required to pay at the time of each visit. We will provide you with an itemized receipt that can be submitted to your insurance company for direct reimbursement to you if we are NOT a provider. All deductibles, co-payments and non-covered services are due at the time service.

BC/BS of MA; HARVARD PILGRIM; TUFTS; AETNA; UNITED HEALTH CARE, ETC: The doctor in this office is a participating provider for these insurance companies. When verification has been completed, we will accept assignment as specified by your particular plan. All deductibles, co-payments and non-covered services are due at the time of service.

MEDICARE: The doctor in this office is participation Medicare provider. All deductibles, co-payments and non-covered services are due at the time service.

WORKER'S COMPENSATION: Patients must complete an Industrial Accident Questionnaire. When verification has been completed and the proper forms are filed, we will accept assignment on work related cases. If the injury is found not to be work related and is denied by the insurance company and the Industrial Accident Board at 600 Washington St., Boston, MA, you are responsible for the payment of any bill either through your medical insurance carrier or yourself.

ACCIDENT AND PERSONAL INJURY: Patients are required to complete a Personal Injury Questionnaire and Accident Report Form. If the patient has been involved in an auto accident, this office also requires a copy of the accident report, coverage selection page of your automobile policy and a copy of your health insurance coverage. If an attorney is involved, you must return the Doctor's Lien Form within 10 days. When the proper forms are filed and verification has been completed, we will accept assignment for medical costs covered by your insurance. We will NOT accept assignment on deductibles, co-payments, on non-covered services.

I have read the information listed above. I understand that I am responsible for all charges from services rendered at Aspire Sports Medicine Inc. if my health insurance do not cover any service rendered.

NAME (print):*_____DATE:_____

SIGNATURE: *_____DATE:*_____

INSURANCE VERIFICATION FORM

1. DATE: _____
2. TIME: _____
3. Name of Insurance Representative: _____
4. "Hello, my name is _____."
5. "I'm calling to verify Chiropractic coverage for MYSELF."
6. "Do I have Chiropractic coverage under my plan?" YES NO
7. When is my Insurance Policy Start/End date? : _____
8. "How many Chiropractic visit is allowed per calendar year and start date?" _____
9. "Is there a Deductible? _____ If YES, how much? _____

   "Are any of the deductible USED to date?" YES NO

   "How much of the total deductible used?" : _____
10. "Is there a Co-Pay or Co-Insurance for each office visit?" YES NO

    If YES how much?_____
11. "Are therapy / modalities covered ?" YES NO Example: 97110_____
12. "Are Bloodwork WORK covered?" YES NO

    If YES, What percentage is covered?"_____
13. "Is X-RAY covered?" YES NO

    If Yes, What percentage is covered?" _____
14. Are MRI covered? YES NO

    If Yes, What percentage is covered?" _____

New Patient Instruction

1. Fill out paper work completely in order to prevent further delay when coming to our office for your first office visit.
2. Please list all the current medication you are taking including self prescribed medication /supplements.
3. List surgeries, this information is critical in providing diagnosis for your complaints.
4. Please get copies (if possible) of imaging such as X-ray or MRI on CD associated to your condition that may have been taken within the past few years.
5. You can verify your insurance coverage to Chiropractic care before you come to our office by checking in your insurance web site or calling your insurance company by using the script we have attached (page 12). This are the same questions we ask the insurance representative to verify your Chiropractic coverage. You can bring this completed script with you on your first visit.
6. Your first office visit will take a minimum of one hour!
7. Our office is Located in Plainville, MA. Our address is: **74 Taunton St Ste 102, Plainville MA 02762**. We are the first building on your right when you turn into the Shepardville Park Office Complex near Loews and across the cemetery.
8. If you need to cancel or reschedule your appointment, ***PLEASE*** contact our office 24 hours before your scheduled time. We schedule one patient at a time. We have patients on waiting list to come in for treatment.

New Form/Paperwork Instructions

1. Please complete pages 1-2-3
2. Pages 4 and 5 are your primary concern/reason for your office visit. Print more page as needed
3. Complete Page 6
4. Page 7 is your confidentiality HIPPA form. Please read, sign and date
5. Page 8, please read sign and date
6. Page 9, please fill-in "Patient Name and DOB. Signature of patient or guardian. **ONLY**" This page is required to get copies of imaging reports such as X-Ray, MRI, etc. to help provide the best care of you.
7. Page 10 and 11, please read, sign and date
8. Page 12 insurance verification script/questions you can use to call your insurance company

Check List for New Patient Appointment VISIT.

1. Bring completed new patient paperwork with you to your initial office appointment
2. Bring a photo ID such as your license.
3. Bring your Insurance card
4. Bring any imaging (X-Ray, MRI, etc) on a cd if available
5. Please arrive several minutes early as we make every effort to be on time with everyone.
6. We look forward to meeting you in our office.