**WELCOME TO ROBERTS FAMILY CHIROPRACTIC CENTER**

**PATIENT INFORMATION**

# PATIENT NAME

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: M F Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# SPOUSE OR GUARDIAN

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY** Name and address of nearest relative or friend not living with you.

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HOW DID YOU HEAR ABOUT OUR OFFICE?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# MY CERTIFICATION

I certify that the above information is correct and I request services.

x \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or person acting on patient’s behalf Date

# MY PRIVACY

I have received a copy of the **Notice of Privacy Practices.** I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third-party payers; Conduct normal healthcare operations such as quality assessments and accreditation.

x \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or person acting on patient’s behalf Date

**MEDICAL AND HEALTH HISTORY**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Main Problem**

What pain causes you to come to the office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What caused this pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did this pain start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long does this pain last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How bad is this pain? (Circle one - 1= mild pain - 10= intense pain) 1 2 3 4 5 6 7 8 9 10

Circle the word or words that best describe the pain:

Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse,

Lightening like, Throbbing, Nagging, Burning Deep, Stinging, Pressure like

How often does the pain occur? (Circle one) Occasional, Frequent, Constant

Does this pain travel to any other area? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes this pain better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes this pain worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What else have you done to treat this pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Problem**

What other pain do you have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What caused this pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did this pain start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long does this pain last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_

How bad is this pain? (Circle one - 1= mild pain - 10= intense pain) 1 2 3 4 5 6 7 8 9 10

Circle the word or words that best describe the pain:

Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse,

Lightening like, Throbbing, Nagging, Burning Deep, Stinging, Pressure like

How often does the pain occur? (Circle one) Occasional, Frequent, Constant

Does this pain travel to any other area? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes this pain better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes this pain worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What else have you done to treat this pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other History**

Do you smoke? Yes No If yes, how many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink? Yes No If yes, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise regularly? Yes No If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant? Yes No Date of last physical exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you employed? Yes No Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How is your overall health? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_

List past illnesses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Vaccinations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgeries / Hospitalizations / Injuries Medications Purpose**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF MEDICARE COVERAGE FOR CHIROPRACTIC CARE**

Your Medicare coverage of chiropractic care is limited. It does not pay for all services. It will only pay for your chiropractic

adjustment (manipulative treatment) when it meets Medicare’s specific rules. There are three categories of Medicare services: 1) non-covered 2) always-covered, and 3) perhaps-covered.

**NON-COVERED SERVICES**

According to existing Medicare law, most of the services in our office are NON-COVERED. Hopefully, the U.S. Congress

will change that someday and treat Doctors of Chiropractic like all other doctors. Until then, here is a summary:

**Examples of Non-Covered Services**

*All Services Other than Chiropractic Adjustments: Various Chiropractic Adjustments or Treatments:*

• Office Visits - to evaluate and manage, re-evaluate, • Non-spinal manipulation to the shoulder, arm, leg, etc.

advise, or give counsel regarding your health.

• Maintenance Care - you are stable and not making any more improvement.

• Physiotherapy - such as massage, traction, electrical • Wellness Care - to promote better health.

stimulation, neuromuscular re-education, etc.

• X-rays, Laboratory, Supplies, Vitamins, etc.

**ALWAYS-COVERED Services**

A Medicare COVERED service is for when you are injured or when you are in pain due to a bad spinal condition. Medicare pays for your rehabilitation as long as you are improving. This phase of care is call “active treatment.” It will be shown on your Medicare claim form and payment reports with your service code. For example, “98940-AT.”

**PERHAPS-COVERED Services**

Your Chiropractic Adjustment must be clinically needed to correct a problem of the spine, according to Medicare rules. If

Medicare determines that your condition is not “Medically Necessary” they will not pay. When we know or believe that your chiropractic adjustment is no longer covered, we will discuss this matter with you. We will also give you a Medicare form known as the Advance Beneficiary Notice (ABN) which will show your financial obligation for continued care.

**MY FINANCIAL RESPONSIBLITY**

I have received the above Medicare information. I understand that I am personally **financially responsible** for all services

not covered by Medicare. I am also responsible for applicable annual deductibles or copayments.

x \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or person acting on patient’s behalf Date

**MY AUTHORIZATION**

I authorize the **release** of any medical or other information necessary to process my claims. I also **request** payment of

government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization

that I may revoke at any time by written notice.

x \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of patient or person acting on patient’s behalf Date

*NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices.*

*If a claim is submitted to a payer, your health information on this form may be shared with the payer. Your health information which the payer sees*

*will be kept confidential by the payer.*

|  |  |
| --- | --- |
| **NECK PAIN DISABILITY INDEX QUESTIONNAIRE**  ***PLEASE READ*: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CIRCLE THE ONE.* *CHOOSE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.*** | |
| ***SECTION 1 - Pain Intensity***     1. **I have no pain at the moment.** 2. **The pain is very mild at the moment.** 3. **The pain is moderate at the moment.** 4. **The pain is fairly severe at the moment.** 5. **The pain is very severe at the moment.** 6. **The pain is the worst imaginable at the moment.** | ***SECTION 6 - Concentration***     1. **I can concentrate fully when I want to with no difficulty.** 2. **I can concentrate fully when I want to with slight difficulty.** 3. **I have a fair degree of difficulty in concentrating when I want to.** 4. **I have a lot of difficulty in concentrating when I want to.** 5. **I have a great deal of difficulty in concentrating when I want to.** 6. **I cannot concentrate at all.** |
| ***SECTION 2 -Personal Care (Washing, Dressing, etc.)***     1. **I can look after myself normally without causing extra pain.** 2. **I can look after myself normally, but it causes extra pain.** 3. **It is painful to look after myself and I am slow and careful.** 4. **I need some help, but manage most of my personal care.** 5. **I need help every day in most aspects of self-care.** 6. **I do not get dressed; I wash with difficulty and stay in bed.** | ***SECTION 7 - Work***     1. **I can do as much work as I want to.** 2. **I can only do my usual work, but no more.** 3. **I can do most of my usual work, but no more.** 4. **I cannot do my usual work.** 5. **I can hardly do any work at all.** 6. **I cannot do any work at all.** |
| ***SECTION 3 - Lifting***     1. **I can lift heavy weights without extra pain.** 2. **I can lift heavy weights, but it gives extra pain.** 3. **Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.** 4. **Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.** 5. **I can lift very light weights.** 6. **I cannot lift or carry anything at all.** | ***SECTION 8 - Driving***     1. **I can drive my car without any neck pain.** 2. **I can drive my car as long as I want with slight pain in my neck.** 3. **I can drive my car as long as I want with moderate pain in my neck.** 4. **I cannot drive my car as long as I want because of moderate pain in my neck.** 5. **I can hardly drive at all because of severe pain in my neck.** 6. **I cannot drive my car at all.** |
| ***SECTION 4 - Reading***     1. **I can read as much as I want to with no pain in my neck.** 2. **I can read as much as I want to with slight pain in my neck.** 3. **I can read as much as I want to with moderate pain in my neck.** 4. **I cannot read as much as I want because of moderate pain in my neck.** 5. **I cannot read as much as I want because of severe pain in my neck.** 6. **I cannot read at all.** | ***SECTION 9 - Sleeping***     1. **I have no trouble sleeping.** 2. **My sleep is slightly disturbed (less than 1 hour sleepless).** 3. **My sleep is mildly disturbed (1-2 hours sleepless).** 4. **My sleep is moderately disturbed (2-3 hours sleepless).** 5. **My sleep is greatly disturbed (3-5 hours sleepless).** 6. **My sleep is completely disturbed (5-7 hours)** |
| ***SECTION 5 - Headaches***     1. **I have no headaches at all.** 2. **I have slight headaches which come infrequently.** 3. **I have moderate headaches which come infrequently.** 4. **I have moderate headaches which come frequently.** 5. **I have severe headaches which come frequently.**   **F I have headaches almost all the time.** | ***SECTION 10 - Recreation***   1. **I am able to engage in all of my recreational activities with no neck pain at all.** 2. **I am able to engage in all of my recreational activities with some pain in my neck.** 3. **I am able to engage in most, but not all of my recreational activities because of pain in my neck.** 4. **I am able to engage in a few of my recreational activities because of pain in my neck.** 5. **I can hardly do any recreational activities because of pain in my neck.** 6. **I cannot do any recreational activities at all.** |

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_ SCORE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**THE REVISED OSWESTRY LOW BACK PAIN QUESTIONNAIRE**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE, JUST CHECK THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

**Section 1 - Pain Intensity**

 The pain comes and goes and is very mild.

 The pain is mild and does not vary much.

 The pain comes and goes and is moderate.

 The pain is moderate and does not vary much.

 The pain comes and goes and is severe.

 The pain is severe and does not vary much.

**Section 2 - Personal Care**

 I would not have to change my way of washing or dressing in order to avoid pain.

 I do not normally change my way of washing or dressing even though it causes some pain.

 Washing and dressing increases the pain but I manage not to change my way of doing it.

 Washing and dressing increases the pain and I find it necessary to change my way of doing it.

 Because of the pain I am unable to do some washing and dressing without help.

 Because of the pain I am unable to do any washing and dressing without help.

**Section 3 – Lifting**

 I can lift heavy weights without extra pain.

 I can lift heavy weights, but it causes extra pain.

 Pain prevents me from lifting heavy weights off the floor.

 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., 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 only lift very light weights at the most.

**Section 4 – Walking**

 Pain does not prevent me from walking any distance.

 Pain prevents me from walking more than one mile.

 Pain prevents me from walking more than 1/2 mile.

 Pain prevents me from walking more than 1/4 mile.

 I can only walk while using a cane or on crutches.

 I am in bed most of the time and have to crawl to the toilet.

**Section 5 – Sitting**

 I can sit in any chair as long as I like.

 I can sit only 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 1/2 hour.

 Pain prevents me from sitting more than 10 minutes.

 I avoid sitting because it increases pain straight away.

**Section 6 – Standing**

 I can stand as long as I want without pain.

 I have some pain on standing but it does not increase with time.

 I cannot stand for longer than one hour without increasing pain.

 I cannot stand for longer than 1/2 hour without increasing pain.

 I cannot stand for longer than 10 minutes without increasing pain.

 I avoid standing because it increases the pain immediately.

**Section 7 – Sleeping**

 I get no pain in bed.

 I get pain in bed but it does not prevent me from sleeping well.

 Because of pain my normal night’s sleep is reduced by less than 1/4.

 Because of pain my normal night’s sleep is reduced by less than 1/2.

 Because of pain, my normal night’s sleep is reduced by less than 3/4.

 Pain prevents me from sleeping at all.

**Section 8 - Social Life**

 My social life is normal and gives me no pain.

 My social life is normal but increases the degree of my pain.

 Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.

 Pain has restricted my social life, and I do not go out very often.

 Pain has restricted my social life to my home.

 I have hardly any social life because of the pain.

**Section 9 - Traveling**

 I get no pain while traveling.

 I get some pain while traveling, but none of my usual forms of travel make it any worse.

 I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.

 I get extra pain while traveling, which compels me to seek alternative forms of travel.

 Pain restricts all forms of travel.

 Pain prevents all forms of travel except that done lying down.

**Section 10 – Changing Degree of Pain**

 My pain is rapidly getting better.

 My pain fluctuates but overall is definitely getting better.

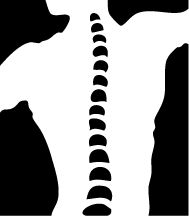
 My pain seems to be getting better, but improvement is slow at present.

 My pain is neither getting better nor worse.

 My pain is gradually worsening.

 My pain is rapidly worsening.

**Score \_\_\_\_\_\_\_\_\_\_ [50] Benchmark -5 = \_\_\_\_\_\_\_\_\_\_**

**Roberts Family Chiropractic Center**

**803 North 2nd Street, Hamilton, MT 59840**

**406-363-2111, Fax 406-363-0836**

**INFORMED CONSENT FOR CHIROPRACTIC TREATMENT**

**Roberts Family Chiropractic Center:**

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

**Sign only after you understand and agree to the above.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of Patient

x\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient Date

x\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Representative Date

(if patient is a minor or is handicapped)

x\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness to Patient's Signature Date

**Maintenance Care Notice**

**Necessity for treat**m**ent by Medicare**

**Medicare does not cover Maintenance** T**herapy for your spinal joint problems.**

**The official Medicare guidelines that define your benefits are reprinted below.**

**Your help is needed to bill Medicare properly.**

**Medicare** C**arriers Manual, Part 3,** C**hapter 2 -** S**ection 2251.3 -** N**ecessity for** T**reatment**

The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient’s condition and provide reasonable expectation of recovery or improvement or function. The patient must have a subluxation of the spine as demonstrated by x-ray or physical exam.

Most spinal joint problems fall into the following categories:

• ***Acute Subluxation*** - A patient’s condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical exam as specified above. The result of Chiropractic manipulation is expected to be an improvement in, or arrest of progression of the patient’s condition.

**• *Chronic Subluxation*** - A patient’s condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition), but where the continued therapy can be expected to result in **some functional improvement.** Once the clinical status has remained stable for a given condition, **without expectation of additional objective clinical improvements**, further manipulative treatment is considered maintenance therapy and is not covered.

**• *Maintenance Therapy*** – Maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy.

In summary, when you have an **Acute** condition (e.g. injury or re-injury), or a **Chronic** condition that needs rehabilitation, it is covered by Medicare. However, Medicare does not cover **Maintenance Therapy** for keeping you well after you are stabilized. The decision-making process in our office for placing you in one of these three categories above is based on:

1) Outcomes assessment scores,

2) Patient history and physical examination, and

3) “Global Impression of Change” by the patient.

If you have questions or disagree with your clinical category, please discuss it with us.

Thank you.

**Our office fees are as follows**:

Exam fee: $60.00 to 300.00

(based on complexity)

Adjustment: $48.00

Cervical X-rays: $130.00

Lumbar X-rays: $90.00

x-rays 2 views: $80.00

x-rays 1 view: $40.00

(elbow, wrist, ankle, knee, shoulder)

**Medicare adjustment fee:**

$32.00 or $42.00