Varney Chiropractic

WELCOME

PERSONAL INFORMATION

PLEASE PRINT

First Name: _____ MI: _____ Last Name: _____

Preferred Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Birthdate: _____/_____/_____ Age _____ Gender: □ Male □ Female □ Unspecified SSN: _____/_____/_____

Primary Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

By providing my email address, I authorize my doctor to contact me via the email address provided.

Best Contact Method: (check one) □ Primary Phone □ Cell Phone □ Work Phone □ Email

Status: (check one) □ Single □ Married □ Divorced □ Widowed □ Separated Children?: □ Yes □ No How Many: _____

Spouse's Name: _____

Emergency Contact: (Name, Relationship, Phone #) _____

Relationship _____ Phone# _____

Family Physician Name: _____ City: _____

How were you referred to Varney Chiropractic? □ Patient _____ □ Physician _____

INSURANCE OR PRIVATE PAY INFORMATION

Please provide insurance card(s) to receptionist.

Type of Insurance: □ Private Ins. □ Medicare □ Auto Ins. □ Worker's Comp □ Other _____

Primary Insurance Carrier: _____ Phone: _____

Policy# _____ Group # _____ Claim# _____

Name of Policy Holder: _____ Relationship to Patient: _____

Policy Holder's Birthdate : _____/____/_____ Policy Holder's SSN: _____/___/_____ Employer: _____

Is patient covered by another insurance? □ Yes □ No

Secondary Insurance Carrier: _____ Policy #: _____

ASSIGNMENT/AUTHORIZATION/RELEASE:

I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Varney Chiropractic of Turner ME all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that "co pays" are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

□ Private Pay/Cash: By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered.

Name of person responsible for this account: _____

X _____ DATE: _____

Signature of Patient, Parent or Legal Guardian (if minor)

REASON FOR VISIT

What is the reason for your visit today? □ Headache □ Neck Pain □ Mid-Back Pain □ Low Back Pain □Other_____

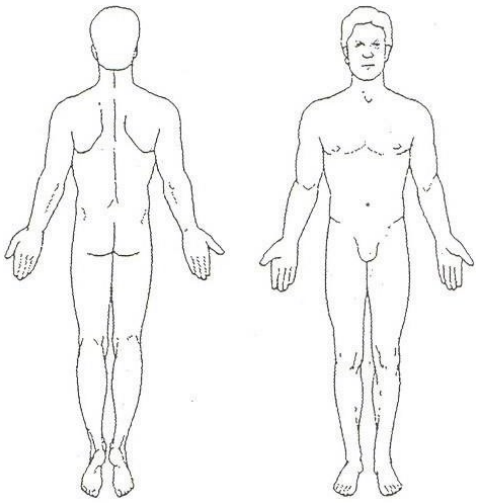
What caused this complaint(s)?_____

_____

When did this complaint begin? _____/_____/_____ Is it getting worse? □ Yes □ No □ Constant □ Comes and goes

Have you had this or similar complaint in the past? □ Yes □ No If "Yes", when?_____

What does your complaint (s) feel like? Circle all that apply: Sharp / Dull / Sore / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness / Other_____



←Please Circle or make an "X" on the body diagram to the left where you have pain

Area for doctor's notes:

On the scale below, please circle the severity of your main complaint right now:

No Pain — Moderate Pain — Worst Possible Pain

0	1	2	3	4	5	6	7	8	9	10

What area(s) does the pain radiate, shoot, or travel to? (if applicable)?_____

What aggravates this complaint? Circle all that apply: Sitting / Standing / Walking / Getting up from seat / Walking stairs / Inactivity / Sleeping / Physical Activity / Exercise / Movement / Bending forward / Bending backward / Twisting / Reaching / Lifting / Desk work / Sneezing / Coughing / Everything / Unknown / Other:_____

What relieves this complaint? Circle all that apply: Sitting / Standing / Walking / Resting / Exercise / Movement / Stretching / Massage / Chiropractic / Heat / Ice / Laying down / Medication / Nothing / Unknown / Other:_____

How often do you experience your symptoms? □ 25% of the day □ 50% of the day □ 75% of the day □ 100% of the day

Timing of complaint: Check appropriate box: □ Morning □ As day progresses □ Afernoon □ Evening □ While sleeping

□ During actvites □ After activities □ Symptoms are constant and do not change □ Other:_____

With time are your symptoms: □ Improving □ Worsening □ Not changing

Have you seen other doctors for this complaint? □ Yes □ No If "Yes", please provide the following information:

Doctor's name:_____Date consulted:_____Diagnosis_____

Is this condition interfering with your: (Circle all that apply) Sleep / Getting in or out of bed or chair / Personal care / Travel / Work / Recreation / Lifting / Walking / Standing / Daily Routine / Social Activities / Exercise / Other:_____

Is your complaint interfering with your daily activities? □ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

NAME:_____ DATE:_____

HEALTH HISTORY

Please check ALL of the health conditions below that apply to you currently or in the past.				Family History Mark ALL conditions that run in your family		Relationship: (Father,Mother,Sister,Brother)
□	Osteoarthritis/Degenerative Joint Disease	□	Whiplash Injury Date of injury:	□	Cancer Type:	
□	Asthma	□	Headaches	□	Anemia	
□	Diabetes □ Type I □ Type II Was your blood/lab work test for hemoglobin A1c > 9.0%? □ Yes □ No □ Not Sure	□	Joint Pain (circle location of pain): Shoulder, Elbow, Hip, Knee, Ankle Other:_____	□	Diabetes (check one) □ Type I □ Type II	
□	Anemia	□	Migraines	□	Heart Problems / Stroke	
□	Cancer/Tumor	□	Osteoporosis /Osteopenia	□	High Blood Pressure	
□	Rheumatoid Arthritis	□	Epilepsy / Seizures	□	Genetic Disorders	
□	Depression/ Anxiety	□	Fibromyalgia / Chronic Fatigue	□	Rheumatoid Arthritis	
□	Disc Herniation	□	Genetic Disorders	□	Other (List):	
□	High Blood Pressure /Hypertension conditions:	□	Please list any other medical			
□	Heart Disease / Stroke					

WOMEN ONLY: Currently Pregnant? □ Yes □No Painful /Abnormal Menstrual Cycle? □ Yes □ No Menopause? □ Yes □ No Miscarriage? □ Yes □ No Do you have children? □ Yes □ No If "Yes",type of birth? Circle Vaginal or C-Section

FRACTURES (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date:)

_____

SURGERIES and/or HOSPITALIZATIONS (List and Date):

_____

Have you had an X-ray or CT scan or MRI of your low back spine in the past year? □ Yes □ No

List current prescription medications, including frequency and dosage if known. If there are NO current medications, check here □

Name of prescription medication	Dosage/Start date	4.	
1.		5.	
2.		6.	
3.		7.	

List any know allergies you have had to prescription medications. If NO medication allergies are known, check here □

1._____ 2._____

SOCIAL HISTORY

Height Ft. In. Weight: Lbs..

Do you exercise? □ Yes □ No Times per week? Intensity? □ Light □ Moderate □ Strenuous Type?:

Do you currently smoke tobacco of any kind? □ Yes □ Former smoker □ Never been a smoker

If "Yes", how often do you smoke: □ Current every day smoker □ Current sometimes smoker Circle level below ↓:
If "Yes", what is your level of interest in quitting smoking? (0 = NO interest, 10=very interested) 0 1 2 3 4 5 6 7 8 9 10

Do you drink alcohol? □ Yes □ No How many drinks per week? For how many years?

Do you drink caffeine? □ Yes □ No How many drinks per day? What type? □ Coffee □ Tea □ Soft Drinks □ Energy Drinks

Do you take pain killers? □ Yes □ No How often? □Daily □ Weekly □ Monthly □ Rarely What type? □ Aspirin □ Ibuprofen □ Tylenol □ Other_____

What do your work duties include? □ Sitting □ Standing □ Light Labor □ Heavy Labor □ Other:

Please describe your overall health right now? □ Excellent □ Very Good □ Good □Fair □ Poor

What is your current stress level? □ Mild □ Moderate □ High

Have you seen a chiropractor in the past? □ Yes □ No

What are your hobbies?

NAME:_____ DATE:_____

INFORMED CONSENT

NAME: _____

To the Patient: ***Please read this entire document prior to signing it.*** It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The Nature of the Chiropractic Adjustment:

The primary treatment used by Doctors of Chiropractic is spinal manipulative therapy and manipulation of other joints and soft tissues (muscle, tendon, lymph, etc.). I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

- Spinal Manipulative Therapy (and manipulation of other joints and soft tissues)
- Palpation / Range of Motion Testing / Vital Signs / Orthopedic Testing / Basic Neurological Testing / Muscle Strength Testing / Postural and Gait Analysis Testing /
- Percussion/Vibration using a massage tool

Initial if you agree to all listed analysis, examination, and treatments: _____

List those you decline: _____

The Risks Inherent in Chiropractic Adjustments:

As with any healthcare procedure, there are certain complications that may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, 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 serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care: however, if you have a condition that would otherwise not come to the Doctor's attention, it is your responsibility to inform the Doctor.

The probability of those risks occurring:

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and examination. If you have a history of Osteopenia or Osteoporosis, then the risk for fractures (especially rib fractures) does increase. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incidence of this complication occurring. If there is a causal relationship at all, it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options:

Other treatment options for your condition may include: self-administered over the counter analgesics, rest, medical care, prescription drugs such as anti-inflammatories/muscle relaxers/pain-killers, hospitalization, or surgery.

If you choose one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated:

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize Dr. Varney (or any other doctor in the office) to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter or other minor under my legal guardianship: _____

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READY AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Varney and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

Patient's Name: _____

Signature: _____

Signature of Parent/Guardian (if a minor): _____

Varney Chiropractic
David W. Varney DC
Ruth L. Varney, DC
Warren D. Varney, DC

1071F Auburn Road
Turner, ME 04282
(207)225-5949

HIPAA ACKNOWLEDGEMENT/CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name _____

Signature _____

Signature Date _____

Relationship to Patient (if patient unable to sign) _____

VARNEY CHIROPRACTIC

Financial Policy

Patient Name:
Date of Birth:

Thank you for choosing Varney Chiropractic for your wholistic healthcare provider. We are committed to your care and treatment. This financial policy is an important part of your care. We ask you to read and agree to the following policy so there are no misunderstandings.

Commercial Insurance
We are out-of-network with all commercial insurances. Upon request we will provide you with a statement so you can self-bill and collect any payments directly from your insurance company at out-of-network rates (if applicable to your individual policy). Payment from you is expected at the time of service.
Medicare:
We do accept National Government Services Medicare and Martin's Point Medicare. Medicare will only cover acute chiropractic spinal manipulation treatment. Any exams, deductibles, co-insurances, co-pays, extremity adjustments, therapies and maintenance/wellness care will be your responsibility as they are considered non-covered services.

Fees:
Below is an estimate by visit type:
New Patient (Total cost for 1st visit): $100 - $135
Re-Examination (Total cost for 1st visit): $85 - $120
Treatment Visits: $50 - $60
We accept cash, checks, Visa, Mastercard and Discover. Any returned check fees will be billed to your account.

Patients with a balance of $100.00 will be required to make a payment on their account and make a payment arrangement before another appointment can be scheduled.
The same policy applies to members of a household where the household balance is $200.
If these balances have been reached, you may be required to pay at-time-of-service moving forward.

Missed Appointments
We request 24 hours notice to reschedule an appointment out of courtesy to other patients who are on our waiting list. ***6 hours notice is required to reschedule or cancel an appointment. One missed/late cancel appointment is allowed free of charge per 365 days. If more than one occurs, each additional incident will incur a $40 fee that will be added to your account.*** *If you miss three (3) appointments without prior notification to our office, you may be dismissed from our practice.*

Questions about this policy? Call Lori at 207-225-5949.
I have read and agree to abide by Varney Chiropractic's Financial Policy.

_____ _____ _____

Signature of Patient or Guardian *Print Name* *Date*

REVIEW OF SYSTEMS

SIGN:

DATE:

check all that apply

GENERAL

- Fever
- Chills
- Night Sweats
- Loss of Appetite
- Sleep Disturbance
- Unexplained Weight Loss/Gain
- Other

EYES

- Blurry/Double Vision
- Other

EAR/NOSE/THROAT/RESPIRATORY

- Sore Throat
- Nasal/Sinus Congestion
- Hearing Loss
- Cough
- Wheezing/Shortness of Breath
- Recurrent Infections
- Other

ENDOCRINE

- Excessive Thirst/Fluid Intake
- Temperature Intolerance
- Excessive Fatigue
- Hot Flashes
- Other

CARDIOVASCULAR

- Chest Pain/Discomfort
- Swelling of Feet/Ankles/Legs
- Arrythmia
- Heart Attack
- Palpitations
- Varicose Veins
- Other

GASTROINTESTINAL

- Abdominal Pain
- Nausea/Vomiting
- Indigestion
- Heartburn
- Bloody Stool/Rectum
- Constipation
- Diarrhea
- Difficulty Swallowing
- Other

PSYCHOLOGICAL

- Depression
- Anxiety
- Other

BLOOD/LYMPH

- Swollen Glands
- Blood Clots
- Easy Bruising
- Bleeding Tendencies
- Other

GENITOURINARY

- Painful Urination
- Urinary Frequency
- Loss of Urinary Control
- Enlarged Prostate
- Difficulty Urinating
- Other

SKIN

- Rash
- Itching
- Discoloration
- Lumps or Masses
- Concerning Moles or Growths
- Other

MUSCULOSKELETAL

- Joint Pain
- Joint Swelling
- Back Pain
- Limited Motion
- Neck Pain
- Pain with Walking
- Other

NEUROLOGICAL

- Tremors
- Dizziness
- Numbness/Tingling
- Headache
- Unsteady Gait
- Weakness
- Seizures
- Other