Varney Chiropractic

WELCOME

PERSONAL INFORMATION

PLEASE PRINT

First Name:______________________M.I._____Last Name:__________________________Preferred Name:___________________

Address:____City:________________________State:______Zip:__________

Birthdate:______/______/______ Age_______ Gender: □ Male □ Female □ Unspecified SSN:_________/______/________

Primary Phone:_______________________ Cell Phone:__________________________ Work Phone:________________________

Home Email:____ Work Email:____

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

Which email would you like us to use to communicate with you? (check one) □ Home □ Work

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

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

Spouse's Name:____________________________________

Occupation:___________________________________ Employer:____

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

Family Physician Name:____City:____

How were you referred to Varney Chiropractic? □ Patient____________________________□ Physician________________________

□ Yellow Pages □ Internet □ Radio □ Newspaper □ Sign □ Other____

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 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_______________

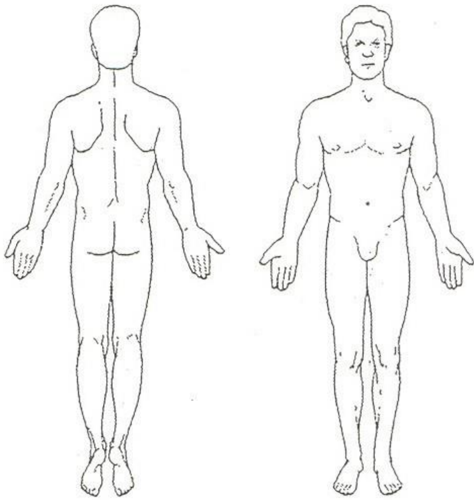
What caused this complaint(s)?____

____

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	☐	Please list any other medical conditions:			
☐	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:_______________________

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 payment directly from your insurance company at out-of-network rates. Payment is expected at the time of service.

Medicare:
We do accept National Government Services Medicare, Humana, Martin's Point & Wellcare. Medicare will only cover acute chiropractic spinal manipulation treatment. Any exams, deductibles, co-insurances, co-pays, extremity adjustments, therapies and maintenance/wellcare will be the patient's 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: $40 - $60

We accept cash, checks, Visa, Mastercard and Discover.

A $25.00 fee will be applied to your account for all returned checks.

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.

Missed Appointments
*Varney Chiropractic **requires a 24 hour notice to cancel appointments**. A $40.00 fee will be charged for appointments that are not rescheduled within **24 hours** of the appointment time. 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, the Billing Manager at 207-225-5949
I have read and agree to Varney Chiropractic's Financial Policy.

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

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) _______________________