Patient Case History

Frederick Family Chiropractic, LLC, 4721 N. Wheeling Ave. Muncie, IN 47304 PH: 765.286.9020

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____Work Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Email Address: _____ Preferred Contact: Home Phone Cell Work E-mail

Employer & Occupation:_____

Date of Birth: _____ Social Security #: _____-_____-_____ Sex: Male Female

Spouse Name:_____ Referred By:_____

Names & Ages of Children:_____

Emergency Contact & Phone Number:_____

Current Medical Doctor & Phone_____

List any **Allergies**: _____

_____

List Any **Medication Allergies** you may have:_____

_____

List any **Surgeries**: _____

_____

_____

List **ALL** **Past Medical History** conditions: (circle all that apply)

Arm Pain	Arthritis	Asthma	Broken bones	Cancer	Chest Pain	Depression	Diabetes
Dizziness	Elbow Pain	Epilepsy	Fainting	Fatigue	Foot Pain	Grave's Dis.	Hand pain
Headaches	Hepatitis	High Blood Pressure	Hip Pain	HIV	Jaw pain	Joint Stiffness	Knee pain
Leg Pain	Low back pain	Leg Pain	Mid Back Pain	MS	Neck pain	Pacemaker	Parkinson's
Polio	Shoulder Pain	Spinal Cord Injury	Sprain/Strain	Stroke	Heart attack		

Other: _____

List **Medications** you are taking (or give us your list and we will copy it):_____

_____

_____

Have you had any auto or other accidents? No Yes Describe: _____

Race (circle one): American Indiana/Alaskan Native Asian Black/African American White Decline to Answer

Ethnicity (circle one): Hispanic/Latino Not Hispanic/Latino Decline to Answer

Smoking History (circle one): Never Smoked Former Smoker Every Day Smoker Some Days Smoker

Date of last physical examination: _____

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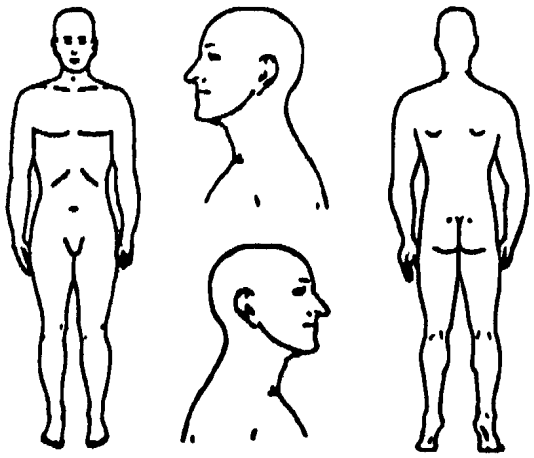
Do you drink alcohol? No Yes - how many per day? _____

Do you drink caffeine? No Yes - how many per day? _____

Do you exercise? No Yes (what forms and how often): _____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

	Become pain free
	Explanation of my condition
	Learn how to care for my condition
	Reduce symptoms
	Resume normal activity level

Have you ever had chiropractic care? No Yes
When? _____Why? _____
Where? _____
Were X-rays taken? No Yes
When was your last adjustment? _____

What is your **FIRST** complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have you had this condition in the past? YES NO

How often do you experience your symptoms?

	Constantly (76-100% of the day)		Frequently (51-75% of the day)
	Occasionally (26-50% of the day)		Intermittently (0-25% of the day)

Describe the nature of your symptoms:

Burning	Dull	Numb	Radiating pain	Sharp	Shooting	Stabbing	Throbbing	Tightness	Tingling

Other: _____

Please rate your pain on a scale of 0 to 10 (0= no pain and 10= excruciating pain) Check one.

	1		**2**		**3**		**4**		**5**		**6**		**7**		**8**		**9**		**10**

If your condition is improving, how much has it improved since it began? (0%= no improvement; 100%=pain is completely gone)

	10%		**20%**		**30%**		**40%**		**50%**		**60%**		**70%**		**80%**		**90%**		**100%**

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

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What is your **SECOND** complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have you had this condition in the past? YES NO

How often do you experience your symptoms?

	Constantly (76-100% of the day)		Frequently (51-75% of the day)
	Occasionally (26-50% of the day)		Intermittently (0-25% of the day)

Describe the nature of your symptoms:

Burning	Dull	Numb	Radiating pain	Sharp	Shooting	Stabbing	Throbbing	Tightness	Tingling

Other: _____

Please rate your pain on a scale of 0 to 10 (0= no pain and 10= excruciating pain) Check one.

	1		**2**		**3**		**4**		**5**		**6**		**7**		**8**		**9**		**10**

If your condition is improving, how much has it improved since it began? (0%= no improvement; 100%=pain is completely gone)

	10%		**20%**		**30%**		**40%**		**50%**		**60%**		**70%**		**80%**		**90%**		**100%**

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

What is your **THIRD** complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have you had this condition in the past? YES NO

How often do you experience your symptoms?

	Constantly (76-100% of the day)		Frequently (51-75% of the day)
	Occasionally (26-50% of the day)		Intermittently (0-25% of the day)

Describe the nature of your symptoms:

Burning	Dull	Numb	Radiating pain	Sharp	Shooting	Stabbing	Throbbing	Tightness	Tingling

Other: _____

Please rate your pain on a scale of 0 to 10 (0= no pain and 10= excruciating pain) Check one.

	1		**2**		**3**		**4**		**5**		**6**		**7**		**8**		**9**		**10**

If your condition is improving, how much has it improved since it began? (0%= no improvement; 100%=pain is completely gone)

	10%		**20%**		**30%**		**40%**		**50%**		**60%**		**70%**		**80%**		**90%**		**100%**

What activities aggravate your condition (working, exercise, etc.)? _____

What makes your pain better (ice, heat, massage, etc.)? _____

Informed Consent

Frederick Family Chiropractic, LLC, 4721 N. Wheeling Ave. Muncie, IN 47304 PH: 765.286.9020

CHIROPRACTIC
Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS
A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Complex (VSC). When VSC complex is found, chiropractic adjustments and other procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. **Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.**

DIAGNOSIS
Although doctors of chiropractic are experts in chiropractic diagnosis and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her condition.

INFORMED CONSENT FOR CHIROPRACTIC CARE
The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. **The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated.** Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS
The purpose of chiropractic services is to promote natural health through the reduction of VSC. Since there are so many variables, **it is difficult to predict the time schedule** or efficacy of the chiropractic procedures. In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT
Please discuss any questions or problems with the doctor **before** signing this statement of policy.

I have read and understand the foregoing.

_____ _____

Date Patient/Guardian Signature

The following is information you should know to help you have a more satisfying relationship with our office staff and chiropractor. Please review this information as well as the financial policy.

PLEASE NOTE

- **Patients scheduled to review x-rays with the doctor** should arrive 10 minutes early and notify the front desk of any changes since last visit.
- **If you are late, you may be asked to reschedule your appointment.** Our doctor makes every effort to stay on schedule and late arrivals will not allow us to do so.

CHECK-IN

All patients must sign in at the front desk. After you check-in, new patients will be asked to turn in the paperwork. Patients will be asked to verify current information such as your address and insurance. You will be asked to present a photo ID for us to photocopy to verify your identity. You may be asked to update our patient information form if we do not have a current one on file. If you have brought with you any MRI'S or other X-rays, they should be given to the front desk.

PATIENTS WITHOUT INSURANCE

We request that 100% of the first visit be paid at the time of the visit. On other visits, payment may be made at the end of the week if you sign a credit guarantee form. We are happy to accept your cash, check, Master Card or Visa.

GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, **not between** your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, **the benefits quoted to us by your insurance company are not a guarantee of payment.** As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. **It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays.**

"ON THE JOB" INJURY (Worker's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.
4. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to 6 months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

MEDICARE

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. **All other services we provide are NON-COVERED.** These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS

Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement.

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

OTHER FEES

- **There will be a twenty-five dollar ($25) fee for all returned checks.**

- **There is a twenty-five dollar ($25) charge for all missed appointments. You can leave a message on our voice mail 24 hours a day.** Your insurance company will not pay this charge. It is your responsibility.

- There is a **twenty dollar ($25) billing charge** for accounts that are sent to the collection agency or that are **over 60 days** past due. I guarantee payment in full of the patients account in accordance with the financial arrangements made at the time of discharge or, if no such arrangements are made, then payment shall be made in full within thirty (30) days of discharge. I agree that in the event of default in payment, reasonable collection agency fees equal to fifty (50) percent of the delinquent balance and reasonable attorney fees, shall be added to the amount due on the account, plus any applicable court costs. Accounts that are not settled within 30 days of being sent to the collection agency will incur additional collection agency fees.

- Frederick Family Chiropractic, LLC is responsible for all records and x-rays in accordance with policy WAC 246-808-650. In keeping with this policy, **the patient may check out x-rays for 60 days. If the x-rays are not returned within 60 days, a fee of $75.00 will be assessed to the patient.**

- We will give you **<u>one copy</u>** of your medical records at no cost. Additional copies of your medical records may be provided for a fee (Indiana Title 16-39-9-3). The fee structure is as follows:
  - Fifteen dollar ($15) copying fee for each medical record request
  - Actual postage costs

I have read and understand the payment policy of Frederick Family Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Frederick Family Chiropractic and my insurance company. I request that Frederick Family Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at Frederick Family Chiropractic that fees will be due and payable immediately.

_____ _____

Patient/Guardian signature Date

Authorization for Appointment Reminders & Scheduling

Frederick Family Chiropractic, LLC, 4721 N. Wheeling Ave. Muncie, IN 47304 PH: 765.286.9020

It is our desire for our staff to use your name, address and/or telephone number, and/or e-mail address for the purpose of contacting you to remind you about scheduled appointments, re-evaluations or other appointment related issues.

The use of this information is intended to make your experience with our office more efficient and productive. If you choose not to authorize this information, your decision will have no adverse effect on your care from the doctor or on your relationship with our staff.

I would prefer to be reminded at this number:_____.
I would prefer to be reminded at this e-mail:_____.
You may also send me a text reminder at this number:_____.

Your signature indicates your authorization of this activity.

_____ _____
Patient/ Guardian Signature Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

Authorization for Release of Information To your Primary Care Physician

It is our wish to work with your medical doctor and keep him/her informed of how you are progressing in our office in order for us to grow a good relationship with your him/her. If you would prefer that we NOT contact your medical doctor, we will not do so.

Name of Medical Doctor:_____

City/State of Medical Doctor:_____

☐YES, you may disclose information to my medical doctor about my care in this office.

☐NO, I would prefer that you NOT contact my medical doctor about my care in this office.

_____ _____
Patient/Guardian Signature Date

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____

Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Noti**c**e of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient/Guardian Signature