Patient Information

Today's Date_____ Acct#_____

Name_____ Social Sec. Number_____

Date of Birth _____Age _____Gender M F Marital Status S M W D # Children_____

Address_____City_____State_____Zip_____

Email_____ Home Phone _____Cell Phone_____

Employer_____Occupation_____Work Phone_____

Emergency Contact_____Relationship_____Phone#_____ How did you hear about us?_____

Have you ever had chiropractic care? Y N How long has it been?_____ The purpose or reason for this appointment_____ What treatment have you already received for your condition? Medications Surgery Physical Therapy Chiropractic None Do you drink alcoholic beverages? Y N How often?_____ Do you smoke? Y N How much?_____ Do you exercise? Y N How often?_____Type?_____ Do you have any allergies? (Specify)_____Date of last physical exam_____ Spinal X-Ray _____Spinal Exam_____ Chest X-ray_____ MRI, CT Scan Bone Scan_____ When was the last time you were involved in an accident of any kind? (Specify)_____ Are you pregnant? Y N First day of last menstrual cycle?_____ # of Pregnancies? _____ Miscarriages?_____

Personal Health History- Please check the box next to each condition you have now or have had in the past

- ○ Dizziness/ Fainting
- ○ Insomnia
- ○ Low Resistance
- ○ Tension
- ○ Confusion
- ○ Fatigue
- ○ Ulcers
- ○ Eye/Vision Problems
- ○ Ear/Hearing problems
- ○ Difficulty Breathing
- ○ Heart Problems
- ○ Loss of Bladder Control
- ○ Constipation
- ○ Diarrhea
- ○ Digestion Problems
- ○ Nausea
- ○ Female Problems
- ○ Prostate Problems
- ○ Hands/ Feet Cold
- ○ Hand tremors
- ○ Loss of Memory
- ○ Nervousness
- ○ Sweaty palms
- ○ Speech Difficulty
- ○ Anxiety
- ○ Irritability
- ○ Broken or Fractured Bones
- ○ Circulatory Problems
- ○ Rheumatoid Arthritis
- ○ Seizures/Convulsions
- ○ A Congenital Disease
- ○ Excessive Bleeding
- ○ High/Low Blood Pressure
- ○ Diabetes
- ○ Osteoporosis
- ○ Epilepsy
- ○ Pacemaker
- ○ Strokes
- ○ Cancer
- ○ Ruptures
- ○ Coughing Blood
- ○ Eating Disorder
- ○ Alcoholism
- ○ Drug Addiction
- ○ HIV Positive
- ○ Gall Bladder
- ○ Head Problems
- ○ Depression
- ○ Tumors
- ○ Mumps, Chicken Pox,

Please identify all medications/ vitamins you have taken or are currently taking and facilities/providers you have seen or are currently seeing, if any, for your presenting problem(s)

Medication List

Medications	Vitamins/Herbs

Problem List

List any injuries: Falls, head Injuries, broken Bones, Dislocations, Surgeries, etc.

_____

_____

_____

_____

_____

Today's **Date**_____ Name_____Acct#_____

Patient History

What is your main complaint?_____

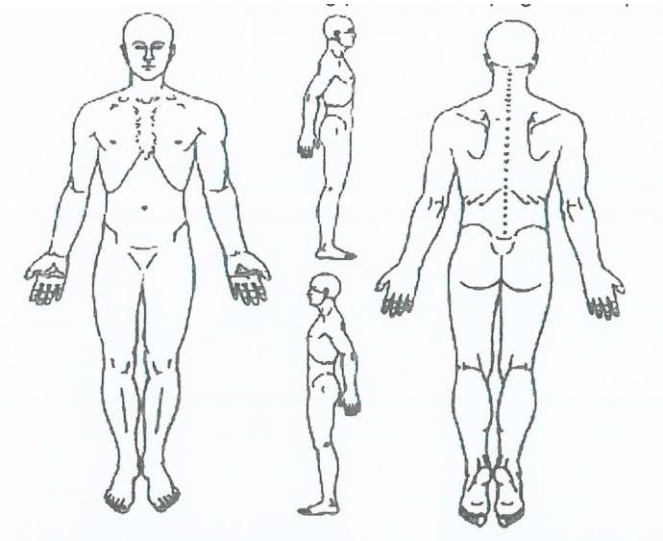
On the scale below, please circle the **Severity** of your **Main Complaint** (At its worst)

None		Slight		Mild		Moderate			Severe
1	2	3	4	5	6	7	8	9	10

On the scale below, please circle the **Percentage of Time** you experience your **Main Complaint**

Occasional			Intermittent			Frequent			Constant	
0	10	20	30	40	50	60	70	80	90	100

On the Diagram below, please show **Where** you are experiencing **all** of your present complaints using the following letters: **A:** ache **B:** burning pain **C:** cramping **D:** dull pain **R:** Throbbing pain **N:** numbing pain **T:** tingling



How **long** have you been experiencing your **main complaint**?

_____

When do you notice it most? AM PM

How long does it last? _____Min HRS

What makes it feel better?_____

What makes it feels worse?_____

Have you ever had this problem in the past? Y N

For this problem I have

- Been hospitalized
- Been treated by another chiropractor
- Been treated by another specialty provider
- Never received care

Have you lost time from work because of it? Y N

Dates? _____to_____

Consent to Evaluation and Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by Dr. Douglas D. Opie, DC and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backdrop for Opie Chiropractic. I understand and I am informed that, in the practice of chiropractic that there are some risks to examination and treatment including, but not limited to, soreness, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments. I intend this consent form to cover the entire course of treatment of my present condition and for any future condition(s) for which I seek treatment. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices.

By signing below, I have read, or have read to me, the above consent to evaluation and treatment statement, and that I certify that my medical information above is corrected to the best of my knowledge.

☐ I acknowledge that I have received **Opie Chiropractic's** Notice of Privacy Practices for protected health information.

Patients or Guardian's Signature_____**Date**_____

If minors, Parent/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 Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal law.

Dated this_____ day of _____, 20 ___

By _____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By _____
Signature of Parent/Guardian (Circle one)

NECK INDEX

Patient Name_____

Date_____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

PAIN INTENSITY

0 I have no pain at the moment
1 The pain is very mild at the moment
2 The pain comes and goes and is moderate
3 The pain is fairly severe at the moment
4 The pain is very severe at the moment
5 The pain is the worst imaginable at the moment

SLEEPING

0 I have no trouble sleeping
1 My sleep is slightly disturbed (less than 1 hour sleepless)
2 My sleep is mildly disturbed (1-2 hour sleepless)
3 My sleep is moderately disturbed (2-3 hour sleepless)
4 My sleep is greatly disturbed (3-5 hour sleepless)
5 My sleep is completely disturbed (5-7 hour sleepless)

READING

0 I can read as much as I want with no neck pain
1 I can read as much as I want with slight neck pain
2 I can read as much as I want with moderate neck pain
3 I can't read as much as I want because of moderate neck pain
4 I can hardly read at all because of severe neck pain
5 I cannot read at all because of neck pain

CONCENTRATION

0 I can concentrate fully when I want with no difficulty
1 I can concentrate fully when I want with slight difficulty
2 I have a fair degree of difficulty concentrating when I want
3 I have a lot of difficulty concentrating when I want
4 I have a great deal of difficulty concentrating when I want
5 I cannot concentrate at all

WORK

0 I can do as much work as I want
1 I can only do my usual work but no more
2 I can only do most of my usual work but no more
3 I cannot do my usual work
4 I can hardly do any work at all
5 I cannot do any work at all.

PERSONAL CARE

0 I can look after myself normally without causing extra pain
1 I can look after myself normally but it causes extra pain
2 It is painful to look after myself and I am slow and careful
3 I need some help but I manage most of my personal care
4 I need help every day in most aspects of self care
5 I do not get dressed, I wash with difficulty and stay in bed

LIFTING

0 I can lift heavy weights without extra pain
1 I can lift heavy weights but it causes extra pain
2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed
3 Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently placed
4 I can only lift very light weights
5 I cannot lift or carry anything at all

DRIVING

0 I can drive my car without any neck pain
1 I can drive my car as long as I want with slight neck pain
2 I can drive my car as long as I want with moderate pain
3 I cannot drive my car as long as I want because of moderate pain
4 I can hardly drive at all because of severe neck pain
5 I cannot drive my car at all because of neck pain.

RECREATION

0 I am able to engage in all my recreation activities without neck pain.
1 The pain is very mild at the moment
2 The pain comes and goes and is moderate
3 The pain is fairly severe at the moment
4 The pain is very severe at the moment
5 The pain is the worst imaginable at the moment

HEADACHES

0 I have no headaches at all
1 I have slight headaches which come infrequently
2 I have moderate headaches which come infrequently
3 I have moderate headaches which come frequently
4 I have severe headaches which come frequently
5 I have headaches almost all the time.

Index Score= [Sum of all statements selected/ (# of sections with a statement selected x 5)] x 100

Neck Index Score

BACK INDEX

Patient Name_____
Date_____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

PAIN INTENSITY

0 I have no pain at the moment
1 The pain is very mild at the moment
2 The pain comes and goes and is moderate
3 The pain is fairly severe at the moment
4 The pain is very severe at the moment
5 The pain is the worst imaginable at the moment

SLEEPING

0 I get no pain in bed.
1 My sleep is slightly disturbed (less than 1 hour sleepless)
2 My sleep is mildly disturbed (1-2 hour sleepless)
3 My sleep is moderately disturbed (2-3 hour sleepless)
4 My sleep is greatly disturbed (3-5 hour sleepless)
5 My sleep is completely disturbed (5-7 hour sleepless)

SITTING

0 I can sit in any chair as long as I like
1 I can only sit in my favorite chair as long as I like
2 Pain prevents me from sitting more than 1 hour
3 Pain prevents me from sitting more than 30 minutes
4 Pain prevents me from sitting more than 10 minutes
5 I avoid sitting because it increases pain immediately

STANDING

0 I can stand as long as I want without pain.
1 I have some pain while standing but it does not increase with time
2 I cannot stand longer than 1 hour without increasing pain
3 I cannot stand longer than 30 minutes without increasing pain
4 I cannot stand longer than 10 minutes without increasing pain
5 I avoid standing because it increases pain immediately

WALKING

0 I have no pain while walking
1 I have some pain while walking but it doesn't increase with distance.
2 I cannot walk more than 1 mile without increasing pain
3 I cannot walk more than 1/2 mile without increasing pain
4 I cannot walk more than 1/4 mile without increasing pain
5 I cannot walk at all without increasing pain

PERSONAL CARE

0 I do not have to change my way of washing or dressing in order to avoid pain
1 My normal way of washing or dressing causes slight pain.
2 My normal way of washing and dressing causes mild pain
3 Washing and Dressing increases the pain and I change my way of doing it.
4 Because of pain I am unable to do some washing and dressing without help
5 Because of pain I am unable to do any washing and dressing without help

LIFTING

0 I can lift heavy weights without extra pain
1 I can lift heavy weights but it causes extra pain
2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed
3 Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned
4 I can only lift very light weights
5 I cannot lift or carry anything at all

TRAVELING

0 I can drive my car without any back pain
1 I can drive my car as long as I want with slight back pain
2 I can drive my car as long as I want with moderate back pain
3 I cannot drive my car as long as I want because of moderate back pain
4 I can hardly drive at all because of severe back pain
5 I cannot drive my car at all because of back pain.

SOCIAL LIFE

0 My social life is normal and gives me no extra pain
1 My social life is normal but increases the degree of pain
2 Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g. dancing etc.)
3 Pain has restricted my social life and I do not go out very often
4 Pain has restricted my social life to my home
5 I have hardly any social life because of pain

CHANGING DEGREE OF PAIN

0 My pain is rapidly getting better
1 My pain fluctuates but overall is definitely getting better
2 My pain seems to be getting better but improvement is slow
3 My pain is neither getting better or worse
4 My pain is gradually worsening
5 My pain is rapidly worsening

Index Score= [Sum of all statements selected/ (# of sections with a statement selected x 5)] x 100

Back Index Score

THIRD PARTY INFORMATION SHEET: NAME:_____
DATE:_____

As a courtesy to you OPIE CHIROPRACTIC'S BILLING OFFICE will file claims on your behalf at no additional charge and send to your insurance company, please fill out the information below. Please make sure that our staff has a copy of your insurance card. **You may also pay the Time of Service Fee (a reduced amount) and submit the bill to your insurance carrier for reimbursement yourself. PLEASE REFFER TO THE FINANCIAL POLICY GIVEN YOU AND READ THE PARAGRAPH THAT BEST FITS YOUR PLAN. Please understand that your insurance company states the "the Information" that they quote "is NOT a Guarantee of Payment" Therefore, you are ultimately responsible for your bill.** We will do all we can to get proper reimbursement but please be aware that the agreement you have with your insurance company is an agreement between you and them, not us.

Insurance Company_____ Phone # _____ Name of Insured_____ Relationship to Patient_____ ID number_____ Group Number_____ Do you have Secondary Insurance? Y N _____	**Do NOT fill out. For Office use only** Deductible? Y N Total?_____ Met?_____ Copay? _____ Co-Ins? _____Visit Limit?_____ Authorization Needed?_____ Patient's/Guardian's Signature _____ Date_____ Witness_____
AUTO/PERSONAL INJURY/WORKER'S COMPENSATION **What Type of Accident?** AUTO WORK OTHER_____ IF WORK, EMPLOYER?_____ WHO DID YOU REPORT TO?_____ Phone #_____ Company Insurance Carrier_____ Contact_____Phone#_____ Claim#_____ **Attorney?**_____ **Phone**?_____	MED PAY (YOUR OWN AUTO INSURANCE) Company_____ Phone #_____ Contact_____ Claim #_____ LIABILITY (SOMEONE ELSE'S INSURANCE, AT-FAULT) Company_____ Phone #_____ Contact_____ Claim #_____

IF YOU ARE ASKING OUR OFFICE TO WAIT FOR PAYMENT FOR YOUR CARE FROM A PARTY OTHER THAN YOURSELF, WE REQUIRE THAT A CREDIT CARD BE LEFT ON FILE UNTIL ALL INFORMATION IS COMPLETE AND VERIFIED.

For Work Comp and Personal Injury cases, insurance and claim information must be received within 3 business days or the card will be charged for the full amount of care..

NAME ON CARD_____BEST CONTACT#_____

MAILING ADRESS_____ZIP_____ TYPE OF CARD VISA M/C DISCOVER

CARD #_____EXP DATE_____ CVV_____

ABOUT MEDICARE COVERAGE

The government's Medicare program only pays Doctors of Chiropractic (DCs) for limited services. If your needed Chiropractic Adjustment (manipulation treatment) meets Medicare's rules, they will usually pay for it. There are three categories of Medicare services: 1) non-covered 2) always covered, and 3) perhaps covered.

NON-COVERED

According to existing Medicare law, most of the available 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:

Examples of Non-Covered Services

All Services Other than Chiropractic Adjustments:	*Various Chiropractic Adjustments:*
-Exams – to evaluate and manage, re-evaluate, advise, or counsel	- Adjustment on an area not on the spine (ex. shoulder arm, leg, etc.)
-Physiotherapy- such as massage, traction, electrical Stimulation, neuromuscular re-education, etc.	-Maintenance Care- you are stable and not making any more improvement
-X-rays, Laboratory, Supplies, Vitamins, etc.	– Wellness Care- to promote better health.

Non-Covered items will appear on your insurance claim form. They will show as a Medicare Non-Covered service like this "72010-GY". The 72010 code is for an x-ray. The –"GY" code means it is not covered, allowing your service to go through the Medicare system. After denial by Medicare, it can then go on to your other insurance. If you have Medigap insurance (also known as Medicare Secondary or Supplemental Insurance) they will pay according to the terms of your contract.

ALWAYS COVERED

A typical example of a Medicare COVERED service (or clinically needed) is when you are in pain due to a bad spinal condition. You should also expect Medicare to cover and pay for your rehabilitation as long as you are improving. When you have a COVERED chiropractic spinal adjustment (manipulation treatment), it will be shown on your Medicare claim form and payment reports as either "98940", "98941" or "98942".

PERHAPS COVERED

Your Chiropractic Adjustment must be clinically needed according to Medicare. If Medicare thinks that your condition is not "Medically Necessary" they won't pay. If we know or believe that Medicare will not pay for your Chiropractic Adjustment due to any rules that they might have, we will let you know. We will give you a special Medicare form known as the Advance Beneficiary Notice (ABN).

STATEMENT OF UNDERSTANDING

I understand that I am personally financially responsible for all Medicare NON-Covered services. I also understand that there could be times when my chiropractic adjustments might not be covered. If so, my doctor will let me know. I am also responsible for any annual deductibles or applicable copayments as required by Medicare.

____ ________________________

Signature of Patient or person acting on patient's behalf Date

- -

LONG-TERM AUTHORIZATION

You won't have to sign again during this time period. This authorization can be revoked upon your written request.

Patient Name______________________________Medicare# (HCIN)__________________________

Provider Name____

Provider Address____

Authorization period From____________ To____________

I request that payment under the Medicare insurance program be made either to me or to the provider named above on any bills for services furnished to me during the effective period of this authorization, and I authorize the above named provider to release to the Social Security Administration or its intermediaries or carriers, or to any other payer for information needed to process claims. I further permit a copy of this authorization to be used in place of the original.

____ ________________________

Signature of Patient or person acting on Patient's behalf Date