PIEDMONT CHIROPRACTIC

PATIENT PRIMARY COMPLAINT FORM

Name: _____ Date: _____

What is the Number one thing that bothers you the most today? _____

_____

When did your pain begin? _____

Pain level: ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Is your condition: ○ Getting better or ○ getting worse / ○ On & Off or ○ Constant

Type of Pain *(circle all that apply)*: ☐ Sharp / ☐ Stabbing / ☐ Burning / ☐ Achy / ☐ Dull / ☐ Stiff & ☐ Sore

Radiating: ☐ Left/☐ Right / ☐ Base of skull / ☐ Shoulder / ☐ Arm / ☐ Hand / ☐ Hip / ☐ Leg / ☐ Knee / ☐ Foot / ☐ Ribs /

Other: _____

What makes it better? ☐ Ice / ☐ Heat / ☐ Rest / ☐ Movement / ☐ Stretching

What makes it worse? ☐ Sitting / ☐ Standing / ☐ Walking / ☐ Lying down / ☐ Sleep / ☐ Overuse / Other:

_____

Have you seen anyone else for this condition? _____

Were you involved in an accident? ○ Auto, ○ Fall, ○ Work, etc?

_____

List of past Surgeries: _____

_____

Do you have any other physical complaints? If necessary, please request another form:

_____

_____

List all medications, dosage, and frequency. If you have a list, may we make a copy of it?

_____

_____

_____

Patient/Authorized Person Signature: _____

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CONFIDENTIAL PATIENT INFORMATION

Please PRINT clearly

PATIENT INFORMATION

Name_____ Preferred Name _____

Address_____ City _____ State _____ Zip _____

Phone: Cell _____ Email _____

Date of Birth _____ Age _____ Spouse _____

Occupation _____ Employer _____ Gender: M/F Married/Single/Other

Who may we thank for referring you to our office? OR How did you hear about us?

_____

EMERGENCY CONTACT INFORMATION

Name _____ Cell _____

Relationship: Child / Parent / Spouse / Other Primary Care Physician _____

Previous Chiropractor _____ Date of last Chiropractic Adjustment _____

FINANCIAL INFORMATION

If auto accident, please complete auto accident insurance form.

Circle One: Insurance / Self pay (cash) / Personal Injury / Auto Accident / Other _____

PRIMARY INSURANCE

If not same as patient:

Relationship to Insured: Self / Spouse / Child / Other

Insured's Name _____

Address _____

City _____ State_____Zip_____

Phone _____

Date of Birth _____

VA patients SSN: _____

SECONDARY INSURANCE

If not same as patient:

Relationship to Insured: Self / Spouse / Child / Other

Insured's Name _____

Address _____

City _____ State_____Zip_____

Phone _____

Date of Birth _____

AUTHORIZATION AND RELEASE

I authorize Dr. States and her assistants to perform a chiropractic examination, x-rays, and treatment as deemed necessary for my care. I authorize payment of insurance benefits directly to this office. I authorize release of any information necessary to communicate with personal physicians and other healthcare providers. I authorize release of any information necessary to secure payment of benefits from insurance companies and/or attorneys. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF CHIROPRACTIC CARE, REGARDLESS OF INSURANCE COVERAGE. I understand that there may be a late fee charged on any amounts due over 30 days.

Patient/Authorized Person's Signature _____ Date _____

Relationship to Patient if not self _____

PIEDMONT CHIROPRACTIC

HIPPAA AND CONSENT FORM

HIPPA

A copy of the full Health Information Policy for our office can be requested at the front desk. In brief, it states that we will not give out any information about you except to parents/guardian if you are a minor or to whomever is responsible for your bill, IE insurance company, third party, or attorney if you have one.

If you would like your information released to another person(s), please list them here:

_____	_____	_____
Name	Relationship	Date of Birth
_____	_____	_____
Name	Relationship	Date of Birth

PREGNANCY WAIVER

By my signature below, I state that to the best of my knowledge that I am not pregnant nor is pregnancy suspected at this time.
OR I am pregnant with an expected due date of _____.

MINOR CONSENT

I authorize Dr. States and her staff to perform examinations, X-rays, and chiropractic care as deemed necessary to _____ (Patient's Name). I further state that I am the custodial parent or have received permission from the custodial parent. I understand that I am responsible for all charges; regardless of any order set forth by the courts and that I, not Piedmont Chiropractic, am responsible for obtaining any monies due to me by the other parent.

INFORMED CONSENT

As with all medical procedures, there is a possibility risk of an adverse effect. Most commonly is an aggravation of symptoms or an increased soreness. This is commonly mild and short term. In rare cases, more severe reactions have been reported, such as rib fracture or stroke. Recent studies have shown that patients most commonly consult a medical doctor or a chiropractor when a stroke is in the early stages and already in progress.

_____	_____	_____
Patient Name (Printed)	Patient/ Guardian Signature	Date

PIEDMONT CHIROPRACTIC

FINANCIAL POLICY

PATIENTS WITHOUT INSURANCE
We request that the first visit to be paid in full at the time of the visit. On other visits, payments may be made according to the financial arrangements. We are happy to accept your 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. The amount they pay varies from one policy to another. 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. *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.* You may also pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees. You may then submit the bill to your insurance carrier for reimbursement.

"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 options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will file a Doctor's Lien with your Med Pay and "At Fault" insurance companies and wait six months after treatment is completed for payment. If you discontinue care, all fees may be due immediately.
3. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

MEDICARE
We do accept assignment from Medicare. Payment is usually sent directly to our office. Medicare will cover only cover the spinal manipulation. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%, unless you have a secondary policy. Some secondary policies have deductible also, for which you are responsible. 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.

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

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.

I have read and understand the payment policy of Piedmont Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Piedmont Chiropractic and my insurance company. I request that Piedmont 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 Piedmont Chiropractic that fees will be due and payable immediately. ***Accounts not paid within terms are subject to a $5 monthly late fee. ____ (Initials)***

Guarantor Signature _____ Date _____

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travelling (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activity

7. Frequency of Pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

_____ _____

Patient's Signature **Date**

For Office Use Only:

Practitioner ID#: _____

Total Score _____ / 40

Clinical Diagnosis Codes:

Patient ID#: _____