E'town Chiropractic Center

Confidential Patient Information

In order for us to understand your health problem properly, please complete this form neatly, accurately, and completely. Thank you.

Date_____ Email_____ cell#_____

Name_____ SS#_____ Home#_____

Street_____ City_____ Zip_____

Age_____ Birth date_____ Marital status S M W D # Children_____

Occupation_____ Employer _____

Address _____ Office phone _____

Name of spouse_____ Occupation_____

Employer_____ Contact # _____

Other Nearest Relative _____ Contact #_____

Heard about our office through? _____

Is this injury do to a work injury? Y N Is this injury do to auto accident? Y N

List present complaints: Details of any accident/injury and when began:

1 _____ _____

2 _____ _____

3 _____ _____

4 _____ _____

5 _____ _____

List other doctors consulted for present complaints and injuries:

Name: _____ When consulted _____

Diagnosis_____ Treatment _____

How long was treatment _____Results _____

Name: _____ When consulted _____

Diagnosis_____ Treatment _____

How long was treatment _____Results _____

Family Doctor _____ Date last seen _____

Please circle any of following conditions:

Pacemaker Cancer Skin Eruptions Heart Condition Epilepsy Pregnant Nerve Damage

Metal Implants: location_____ Recent surgery: location _____

What surgeries have you had

Type/When/Doctor/Remarks _____

_____

_____

List former serious accidents and falls: (auto, work, home, leisure, sports, other - circle one)

What/When/Symptoms/Treatment/Results _____

_____

_____

List broken bones:

What/When/Remarks _____

_____

_____

List medications and/or diet supplements you take:

What/Frequency/Doctors/Side Effects/Remarks _____

_____

_____

Environment

Work - (Please circle appropriate answer)

Seated/Standing - Work Bench/Desk/Counter/Other _____

Job involves - Lifting/Bending/Stooping/Twisting/Turning/Carrying/Walking/Standing/Other _____

Chair - Executive/Steno/Bench/Stool/Folding/Other _____ Shoes - High heels/Boots/Other _____

Leisure

Sedentary activities? Standing/Seated/Lying? TV/Reading/Card Games/Sewing/Other (Please describe) _____

_____

Strenuous activities? Exercise - Type/Frequency/Length of time? _____

_____

Sports - Type/Frequency/Length of time? _____

If you have discontinued sports or strenuous activities, why the change? _____

Exert Yourself - Frequently/Occasionally/Rarely/Never? Describe how? _____

_____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
☐	☐	☐	AIDS	☐	☐	☐	dislocated joints	☐	☐	☐	neck pain
☐	☐	☐	anemia	☐	☐	☐	epilepsy	☐	☐	☐	nervousness
☐	☐	☐	arthritis	☐	☐	☐	German measles	☐	☐	☐	numbness
☐	☐	☐	asthma	☐	☐	☐	headaches	☐	☐	☐	polio
☐	☐	☐	back pain	☐	☐	☐	heart trouble	☐	☐	☐	poor circulation
☐	☐	☐	bladder trouble	☐	☐	☐	reproductive disorders	☐	☐	☐	hepatitis
☐	☐	☐	bone fracture	☐	☐	☐	high blood pressure	☐	☐	☐	rheumatic fever
☐	☐	☐	cancer	☐	☐	☐	HIV/ARC	☐	☐	☐	rheumatism
☐	☐	☐	chest pain	☐	☐	☐	kidney disorder	☐	☐	☐	scarlet fever
☐	☐	☐	concussion	☐	☐	☐	bowel control loss	☐	☐	☐	serious injury
☐	☐	☐	convulsions	☐	☐	☐	menstrual cramps	☐	☐	☐	sinus trouble
☐	☐	☐	diabetes	☐	☐	☐	multiple sclerosis	☐	☐	☐	tuberculosis
☐	☐	☐	indigestion	☐	☐	☐	muscular dystrophy	☐	☐	☐	venereal disease

Have you been treated by a physician for any health condition in the last year? Yes ☐ No ☐

Patient Health Questionnaire - PHQ

ACN Group

ACN Use Only rev 9/11/2002

Patient Name _____ *Date* _____

1. Describe your symptoms _____

_____

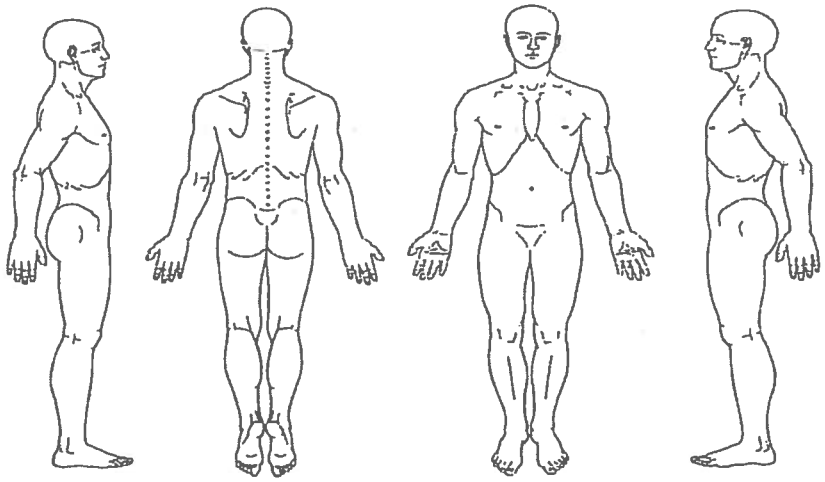
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the <u>past 4 weeks</u>:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the <u>past 4 weeks</u> how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ *Date* _____

This is a functional assessment questionnaire that is important to determine how your current health condition is affecting your daily life. Please fill out this form as accurately as you can.

In the space by each activity, write the number that corresponds with the level of restriction.

(0)-No difficulty, (1)- Mild difficulty, (2)- Moderate difficulty, (3)- Severe difficulty, (4)- Can't Do

Pain level: 0- 10, 0- no pain—10- unbearable pain: Rating: _____

Sleep: _____

Driving a car: _____

Recreation: _____

Lifting 10-25 lbs: _____

50 lbs +: _____

Static standing: _____

Overhead reaching: _____

Pet care: _____

Computer use: _____

Climb stairs: _____

Carry groceries: _____

Household chores: _____

Yard work: _____

Caring for family: _____

Going down stairs: _____

Self Care -Dress, bath, shave, etc.:_____

Job Performance: _____

Lifting 0-10 lbs: _____

Lifting 25+ lbs : _____

Walking: _____

Kneeling (e.g. weed garden) : _____

Changing position from sit to stand: _____

Reading (concentration): _____

Feeding/eating: _____

Sexual activities: _____

Static sitting: _____

Lifting children: _____

Bending to tie/put on shoes: _____

Getting into/out of car: _____

All the information that I have provided is true and factual to the best of my knowledge.

Signature _____ Date _____

FINANCIAL RESPONSIBILITY STATEMENT

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, against the Doctor's recommendation, my account balance will be immediately due and payable. I also agree to pay any and all expenses the Doctor may incur for the collection of my account.

Patient's Signature _____ S.S. # _____ Date _____

Other Responsible Party ___ _____ S.S. # _____ Information taken by _____

PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

_____ , hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a post card mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or the individual answering the phone.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and necessary for the Practice to conduct specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this Consent.

7. I understand that if I revoke this Consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____
Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent if a minor) Relationship

_____ _____
Date Signed Witness

E'TOWN CHIROPRACTIC & NATUROPATHIC CENTER
620A WESTPORT ROAD
ELIZABETHTOWN, KY 42701
270-769-9844

PATIENT_____

ADDRESS _____

ATTORNEY _____

INSURANCE CARRIER _____

POLICY NUMBER _____

My attorney and/or insurance company are hereby requested and authorized to pay directly to: Dean W. Tindall, DC, DCP, DABCO any monies due to him on account, paid first by the paying insurance carrier, with any remaining balance to be paid for out of settlement made on my behalf.

Further, I agree to pay Dean W. Tindall, DC, DCP, DABCO the difference, if any, between the total amount of his charges and the amount paid him by the attorney and/or insurance carrier. It is further understood that I, the undersigned, agree to pay Dean W. Tindall, DC, DCP, DABCO The full amount of his charges, should my condition be such that it is not covered by my policy, or for any reason the insurance carrier refuses to cover the claim.

Dated at: E'town Chiropractic- Elizabethtown, Kentucky

This_____day of _____, 20___

Witness_____

_____

Patient Signature

E'town Chiropractic Center

620 A Westport Road
Elizabethtown, KY 42701

Dr. Dean W. Tindall, DC, DCP, DABCO

EXPLANATION OF CHIROPRACTIC MEDICARE BENEFITS

Medicare does cover chiropractic care but with limitations. The only service allowed by Medicare is Chiropractic Manipulative Treatment (CMT). Medicare does not cover the cost of x-rays. Also, they do not cover any therapy, supports, supplements, examinations or other services offered in this office.

We are a Medicare provider but do not accept assignment of payment from Medicare. It is your responsibility to pay for the services rendered in this office. We will submit a claim on your behalf at no additional cost to you.

"Medicare will only pay for services that it determined to be 'reasonable and necessary' under section 1862(a)(1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is 'not reasonable and necessary' under Medicare program standards, Medicare will deny payment for that service". I believe that in your case, Medicare is likely to deny payment for Chiropractic Manipulative Treatments (CMT) for more than 12 visits for the following reason: Normally, Medicare only allows 12 visits for this procedure code. Medicare may allow more visits upon further documentation.

I have been notified by my physician that he or she believes that in my case, Medicare is likely to deny payment for the services identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

_____ _____

Patient Signature Date

_____ _____

Witness Date

medicare.doc

E'town Chiropractic Center
620 A Westport Road
Elizabethtown, KY 42701

Non-Covered Service Notice 2017

Name: _____ SS# _____

This notice is to inform you of the Medicare benefits for chiropractic services in the state of **Kentucky**. It is **your choice** to receive these services.

Medicare will not pay for the following services by this chiropractic office: **X-rays, Exams, Re-exams, therapy, orthopedic appliances, vitamins or lab work.**

Medicare is a federally regulated program that limits the coverage of chiropractic services to spinal adjustment. The charges for spinal adjustments are:

$30.00 for 98940
$35.00 for 98941
$40.00 for 98942

The first visit may consist of an exam at $20.00, and-or x-rays at $99.00.

The therapy charge is $10.00 for each visit. This is paid each day of treatment.

This is all contingent on Medicare's **$183.00 deductible** that must be met before Medicare will pay any benefits.

The Medicare law states: "Medicare will only pay for services that are determined to be "reasonable and necessary" under section 1862 (a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be a covered, is not "reasonable and necessary" under the Medicare program standards, Medicare will deny payment for that service."

If you receive more adjustments then deemed reasonable by Medicare in a 12 month period starting in January and ending in December and are not covered by Medicare, they will be your responsibility.

Medicare will disallow some services as either a non-covered service or not medically necessary. You could receive a letter or EOB to that effect. It is my opinion that your care requires more treatment then allowed by Medicare.

Ask us to explain if you don't understand any of the above,
This has been read and is your personal agreement to pay for all the charges that are disallowed under Medicare benefits.

Date:_____ Patient Signature: _____

Witness:_____ Date: _____

E'TOWN CHIROPRATIC CENTER
620 A WESTPORT ROAD
ELIZABETHTOWN, KENTUCKY 42701
(270) 769-9844

MEDICARE SIGNATURE ON FILE

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OT TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.

PATIENT SIGNATURE _____

WITNESS _____

DATE _____

E'town Chiropractic Center, 620A Westport Rd., Elizabethtown, KY. 42701

270-769-9844

Kentucky State Law requires healthcare providers to obtain your **INFORMED CONSENT** prior to examination and treatment. The purpose of this form is to inform you, not alarm you. What you are being asked to sign is confirmation that you have been informed of the following:

Examination & X-rays: this office uses highly sensitive x-ray film, intensifying screens, and filters that provide high quality x-rays with the lowest possible x-ray exposure. The only noteworthy risk with taking x-rays deals with pregnancy. If there is any possibility that you are pregnant, inform us prior to any x-ray examination. If there is no possibility of this condition, the inherent risks are so rare that we have no available statistics to quantify their probability.

PLEASE CIRCLE ONE AND INITIAL: I AM / I AM NOT pregnant at this time / Does Not Apply Initial: _____

****

Chiropractic Adjustment/ Chiropractic Manipulative Therapy (CMT): The doctor will use his hands or a mechanical device upon your body in such a way as to move your joints in various directions. This procedure may cause an audible "pop" or "click" to be heard coming from your joints, which is not cause for alarm. There are some material risks involved in doing these procedures as they are as follows:

-Pain: Chiropractic treatments may result in a temporary increase in soreness in the area receiving treatment.

-Rib Fractures: Fractures caused by chiropractic care are rare. They occur most frequently in patients with osteoporosis or weakened bones. Evidence of osteoporosis can be noted on your x-rays, and if detected, the most appropriate, gentle treatments are used, minimizing the possibility of fractures to the ribs.

-Disc Injury: Chiropractic treatment is appropriate for the treatment of many kinds of back problems, including some disc problems (1). Occasionally, chiropractic treatment may aggravate or cause a problem if the disc is in a severely weakened state. However, this occurs so rarely that statistics to quantify the probability are unavailable, but estimates place the risk of serious injury *about 1 serious complication per 100 million low back manipulations* (2).

- Vertebral Artery Dissection (VAD)/Stroke: The overall incidence of vertebral artery dissection leading to stroke in the general population is about *2 per 1000 people* (3). Although chiropractic adjustments/manipulation has been implicated as a possible cause of stroke, this possibility is very rare. The best available data suggests that a stroke is secondary to chiropractic adjustment/manipulation may occur 1 per 500,000 patients (4)-a rate well below the overall risk in the general population. In comparison, the overall risk of death from taking non-steroidal anti-inflammatory drugs (i.e. Aspirin, Ibuprofen, Naproxen Sodium, etc.) is 4 per 10,000 patients (5). The risk of serious complications or death from spine surgeries of the neck is 11.25 per 1,000 patients (5). As you can see, the risk of stroke from chiropractic treatments is much lower than other common medical treatments. Even though the risk is small, we have implemented procedures and tests that will likely reduce the potential for stroke even more.

-This list is of side-effects is not exhaustive and there could be other negative side-effects of various treatments rendered in this office.

Initial: _____

I understand the risks and possible negative side effects of Chiropractic Care, Massage Therapy, and other therapeutic modalities and treatments at E'town Chiropractic Center that are involved in my treatment, and I have had the chance to ask questions of the doctor and staff regarding these procedures and make an informed decision in the treatment of my condition(s). By initialing these sections and signing this statement I authorize Dr. Tindall and any or all members of E'town Chiropractic Center staff to treat me using the method designed by Dr. Tindall.

Chiropractic is a second largest system of health delivery. As with any health care delivery system, we cannot promise a cure for any system, disease, or condition as a result of treatment in this office. We will always give you our best care, and if your results are not acceptable, we will refer you to another health care provider who we feel will assist your situation.

DATE: ____/____/_____

PATIENT SIGNATURE: _____ SS# ____/____/_____