Today's Date:_____

PATIENT INFORMATION

Name: _____ (Age) _____ Gender: M F Birth Date: ____ / ____ / _____

Home Address: _____ City, State, Zip: _____

Home Phone: ( ) _____ Work: ( ) _____ Mobile: ( ) _____

Email Address: _____ SSN #: _____ - _____ - _____ Marital Status: S M D W

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Spouse's Employer: _____ Occupation:_____

Names of Children: _____ Ages:_____

Emergency Contact: _____ Phone: ( ) _____ Relationship to Patient:_____

Who/ How were you referred to this office? _____

Doctor Notes:

PURPOSE OF THIS VISIT

Your symptoms: ☐ Back Pain ☐ Neck Pain ☐ Shoulder Pain ☐ Wrist Pain ☐ Hip Pain ☐ Knee Pain ☐ Foot Pain ☐ Headaches
☐ Weight gain ☐ Snoring ☐ Sleep problems ☐ Other symptoms _____

How long ago did **your most troubling symptom** start? ☐1-2 weeks ☐2 wks-2 mths ☐2-6 mths ☐6-12 mths ☐Other _____

What happened? _____

Is this condition related to: ☐ Auto Accident ☐ Work Injury If so, date of injury: _____

Is this condition getting worse? ☐ Yes ☐ No Is this condition: ☐ Constant ☐ Comes & goes ☐ Activity related

Please circle your **worst** pain level in the past couple of days: (Mild) **0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10** (Severe)

What aggravates symptoms? ☐ Driving ☐ Reaching ☐ Lifting ☐ Stairs ☐ Walking ☐ Sitting ☐ Standing ☐ Prolonged Positioning

Prior level of function: ☐ Normal/No complaints ☐ Limits_____

Does complaint(s) interfere with: ☐ Work ☐ Sleep ☐ Hobbies ☐ Daily Routine Explain: _____

Is there anything, which has relieved your symptoms? ☐ Yes ☐ No Describe: _____

Have you experienced this condition before? ☐ Yes ☐ No If so, please explain: _____

Whom have you seen for this? _____ What did they do? _____

How did you respond? _____

EXPERIENCE WITH CHIROPRACTIC • PT • ACUPUNCTURE • INJECTIONS

Have you seen a **Chiropractor** before? ☐Yes ☐No Who? _____ When? _____

Reason for visits: _____ How did you respond? ☐ Better ☐ Worse ☐ No Change

Did your previous chiropractor take before and after x-rays? ☐ Yes ☐ No

Have you seen a **Physical Therapist** before? ☐ Yes ☐ No Who? _____ When? _____

Reason for visits: _____ How did you respond? ☐ Better ☐ Worse ☐ No Change

Have you seen an **Acupuncturist** before? ☐ Yes ☐No Who? _____ When? _____

Reason for visits: _____ How did you respond? ☐ Better ☐ Worse ☐ No Change

Have you had **Knee Injections** before? ☐ Yes ☐ No ☐Steroid ☐ Fluid Supplement Who?_____ When? _____

Reason for visits: _____ How did you respond? ☐ Better ☐ Worse ☐ No Change

Today's Date:_____

MEDICAL HISTORY

Please list any **current medications** ☐ See Med List

_____ _____

_____ _____

Please list any **medicine allergies** ☐ N/A

_____ _____

_____ _____

Have you been diagnosed with depression, generalized anxiety, bipolar, schizophrenia? **Y N**

Please check/ list **any and all surgeries** you have had:

☐ Tonsillectomy ☐ Gall bladder removal ☐ Hysterectomy

☐ Spinal fusion ☐ Spinal laminectomy ☐ Cesarean

☐ Carpal Tunnel

_____ _____

_____ _____

List any medical problems that other doctors have diagnosed:

_____

Check any and all of the following that you have experienced in the last 6 months?

□ Chest Pain	□ Difficulty Breathing	□ Abdominal Pain	□ Pain in joints	□ AnyWeakness
□ Palpitations	□ Hearing changes	□ Vision changes	□ Cough	□ Asthma/wheezing
□ Nausea/Vomiting	□ Diarrhea	□ Constipation	□ Black/reddish stools	□ Urination difficulties
□ Headache/ Migraine	□ Dizziness/ Fainting	□ Seizures	□ Fatigue	□ Numbness/Tingling
□ Snoring	□ Sleep difficulties	□ Weight gain	□ Weight loss	□ Stress
□ Reflux/Heartburn	□ Recurrent colds	□ Allergy/Hay fever	□ Thyroid problems	□ Ulcer
□ Depression/ Anxiety	□ Hair falling out	□ Menstrual discomfort	□ Mood swings/irritability	□ Rash

□ Are you a smoker? □ Never Current: _____ pk/day Previous: _____ years

□ Do you drink? □ Never Current: _____ drinks per week □ Social Settings/On occasion

Any other substance use? **Y N** _____ How frequently? _____

□Other:_____

_____

**** FOR STAFF USE ONLY ****

☐**Chiro**

1st Diagnosis **1)** _____ **2)** _____ **3)** _____ **4)** _____ **DR Init.** _____ ☐**PT**

2nd Diagnosis **1)** _____ **2)** _____ **3)** _____ **4)** _____ **DR Init.** _____ ☐**Medical**

E / M: ☐ WELLNESS (99201) ☐ 99202 ☐ 99203 ☐ 99204 ☐ 99205

X-ray: ☐ 72042 (C) ☐ 72080 (T) ☐ 72100 (L) ☐ 72020 (Single) ☐ 73560 (Knee) ☐ 73562 (Knee)

PT: ☐ 97001 ☐ 97002 ☐ 97140 ☐ 97110 ☐ 97112 ☐ 97530 ☐ 29200 ☐ 29240 ☐ 29530 ☐ 29540 ☐ 29260

NEXT VISIT: ☐ ROF: Spine ☐ ROF: Knee ☐ ROF: Headache ☐ TREATMENT ☐ Medical Initial ☐ Chiro Eval

X-RAYS: **C** **T** **L** **Knee**

Visit Frequency: _____ x a week for _____ weeks **OR** PRN **Height**: _____ **Weight**: _____

Comments: _____

_____

Today's Date:_____

INSURANCE INFORMATION

I clearly understand that all insurance coverage, whether accident, work related, or general health coverage is an arrangement between my insurance carrier and myself. I understand that if this office chooses to bill any services to my insurance carrier they are performing these services strictly as a convenience to me. Advanced Spine & Wellness Center will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid claims or balances.

I understand that there may be some services that my insurance company will not cover. If my insurance company notifies me that they are refusing payment for any services I have received, I will contact Advanced Spine & Wellness Center immediately to notify them of the nonpayment/rejection notice. I authorize the assignment of all insurance benefits to be directed to Advanced Wellness Systems, LLC (d/b/a Advanced Spine & Wellness Center) for services rendered.

Patient's Signature_____ Date_____

Parent/Guardian's Signature _____ Date_____

Who should receive charges on your account?

☐ Health Insurance ☐ Medicare ☐ Auto Insurance ☐ Workers' Compensation

☐ Patient ☐ Spouse ☐ Parent/Guardian

Name of Insurance Co. _____ Policy #_____

Policyholder information (if different from patient)

Insured's Name_____ Insured's Birth Date _____/_____/_____

Patient's Relationship to Insured _____ Insured's SS # (optional) _____

Do you have a secondary or supplemental insurance policy? ☐ Yes ☐ No

Secondary Insurance Co. _____ Policy #_____

If auto accident or work injury:

Accident Location (City & State) _____ Date of Injury _____/_____/_____

Which auto insurance should be billed for medical claims?
If you have a **Maryland** policy, we must bill the vehicle owner's insurance or your auto insurance, NOT the at-fault party's.
If you have a **Virginia** policy, we must bill your auto insurance or the vehicle owner's insurance, NOT the at-fault party's.
If you have a **DC** policy, we must bill your health insurance first; then your auto insurance if the accident happened outside DC.
Please note: We cannot bill the at-fault party's auto insurance; we are required to bill your auto insurance or health insurance.

Insurance Carrier _____ ☐ patient's insurance ☐ vehicle owner's

Claim # _____ Policy State _____

Adjuster _____ Phone # _____

Mailing Address _____ Fax # _____

Personal Injury Protection (PIP) or Med-Pay Policy Limit $_____ Used $_____

Do you have an attorney on your case? ☐ Yes ☐ No

Attorney _____ Phone # _____

Mailing Address _____ Fax # _____

Today's Date:_____

CARE AUTHORIZATION

I hereby authorize Advanced Spine & Wellness Center (ASWC) and its licensed doctors/specialists, based on my complaints and the history I have provided, to undertake an examination and provide treatment which may include chiropractic adjustments, manual therapies, modalities and other tests and procedures considered therapeutically appropriate. I also wish to rely on ASWC doctors/specialists to make those decisions about my care, based on the facts then known, that they believe are in my best interest. The specifics of the provider's recommended treatment plan will be further explained during a Report of Findings following the examination and any subsequent examinations and significant changes in your diagnosis or treatment plan.

I acknowledge that: (1.) ASWC may not be a participating insurance provider (2.) ASWC has applied to become a participating insurance provider (3.) the insurance carrier has not yet completed the assessment of qualifications of the treating provider to provide services as a participating provider; and any covered services received must be reimbursed by the insurance carrier at the participating provider rate.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The health care providers will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural or extremity conditions diagnosed at this clinic.

By signing below I acknowledge my consent to be examined and allow ASWC, as deemed appropriate by the examining physician, to take radiographs (x-rays) of my spine and/or extremities. I affirm that to my knowledge that I am not pregnant. _____ **(Initial)**

Patient's Signature_____ Date_____

I hereby authorize ASWC to administer care as deemed necessary to my child or dependent, a minor under the age of 18 years old.

Parent/Guardian's Signature _____ Date_____

NOTICE OF PRIVACY PRACTICES

We care about our patients' privacy and are committed to protecting the confidentiality of your personal and medical information. We are required by law to maintain the privacy of protected health information and to inform you of our privacy practices.

Treatment at Advanced Spine & Wellness Center is provided in an open room where other patients are also being treated. Other persons in the office may overhear some of your health information during the course of your treatment. Should you need to speak with your health care provider in private, the doctor or specialist will provide a private room for these conversations. You may also request a private room should you need to discuss financial matters with a billing professional.

Your personal information and clinical records may be used for the following purposes:

- To provide you the best care and service possible, including for quality control and training purposes.
- To contact you with appointment reminders, health-related email messages, and birthday or holiday cards.
- To coordinate treatment with other health care professionals, including referring practitioners and primary care providers.
- To obtain payment, billing information and medical records may be provided to your insurance and to our billing service.

You have the following rights with regard to your health information:

- The right to review the above notice prior to signing this consent.
- The right to receive a copy of this notice of privacy practices for your records.
- The right to request restrictions as to how your personal or contact information may be used. Requests must be in writing.
- The right to request copies of your medical records. There may be a reasonable fee for photocopying and postage.
- The right to ask us, in writing, to amend your medical records if you feel the information is incomplete or inaccurate.
- The right to file a written complaint with our office or with the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be penalized or discriminated against for filing a complaint.

I have reviewed the notice of privacy practices provided to me by Advanced Spine & Wellness Center and grant permission for ASWC to use and disclose my protected health information in accordance with the conditions listed above.

Patient or Parent/Guardian's Signature _____ Date_____

May we include you on our email list? ☐ YES ☐ NO (You will be included unless you opt out.)