PAIN & ARTHRITIS RELIEF CENTER

PATIENT INFORMATION

Date

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?

PAIN ASSESSMENT

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) ☐☐☐☐☐☐☐☐☐☐ (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 that has relieved your symptoms? ☐ Yes ☐ No Describe:

Have you experienced this condition before? ☐ Yes ☐ No Describe:

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

How did you respond?

CHIROPRACTIC • PHYSICAL THERAPY • ACUPUNCTURE

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

Patient Name: _____ Date: _____

MEDICAL HISTORY

Please list any current medications ☐ See Med List

_____ _____

_____ _____

Please list any medicine allergies ☐ N/A

_____ _____

_____ _____

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

☐ Tonsillectomy ☐ Gall bladder removal ☐ Hysterectomy

☐ Spinal fusion ☐ Spinal laminectomy ☐ Cesarean

☐ Carpal tunnel

_____ _____

_____ _____

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

List any medical problems that other doctors have diagnosed:

_____

Check any and all of the following that you have experienced in the past 12 months:

☐ Chest pain	☐ Difficulty breathing	☐ Abdominal pain	☐ Pain in joints	☐ Any weakness
☐ 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	☐ Weight loss	☐ Sinusitis
☐ 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?: _____

FOR STAFF USE ONLY

1st Diagnosis 1) _____ 2) _____ 3) _____ 4) _____ DR Init. _____

2nd Diagnosis 1) _____ 2) _____ 3) _____ 4) _____ DR Init. _____

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

Vitals: BP: _____ HR: _____ RR: _____ T: _____

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

Any other substance use? C T L Knee

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

Patient Name: 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. Pain & Arthritis Relief 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 Pain & Arthritis Relief 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 Pain & Arthritis Relief 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? Y N

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? Y N

Attorney Phone #

Mailing Address Fax #

CARE AUTHORIZATION

Patient Name: _____

I hereby authorize Pain & Arthritis Relief Center (PARC) and its licensed doctors/specialists, based on my complaints and the history I have provided, to undertake an examination and provide treatment that may include chiropractic adjustments, manual therapies, modalities and other tests and procedures considered therapeutically appropriate. I also wish to rely on PARC 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.) PARC may not be a participating insurance provider (2.) PARC 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 PARC, 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 PARC to administer care as deemed necessary to my child or dependent, a minor under the age of 18 years old.

Patient'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 Pain & Arthritis Relief 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 that 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 that 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 Pain & Arthritis Relief Center and grant permission for PARC to use and disclose my protected health information in accordance with the conditions listed above.

Patient's Signature _____ Date _____

May we include you on our email list? [Y] [N] (You will be included unless you opt out.)