SUPERIOR SPINE CARE
CHIROPRACTIC MASSAGE REHABILITATION

P 440.716.8400 F 440.716.8401

Date: _____

# Confidential Patient Information

Patients Name: _____ How did you hear about us: _____

Address: _____ Home Phone: _____

City: _____ Zip:_____ Cell Phone: _____

SS#: _____ Email: _____

Date of Birth: _____ Marital Status: M S W D

Occupation: _____ Employer: _____

**Our practice sends electronic messages via email and text. Do you consent to receiving electronic messages from us? Y / N**

Ins. Company: _____ Ins. Phone #: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder DOB: _____

**Are your present symptoms or condition related to, or the result of an auto, work-related, or other personal injury? Y / N**

Family Physician(PCP): _____ ( May we send your health information to this provider **Y / N**)

Family Physician Phone Number: _____ Did your PCP give you a referral? **Y / N**

Person to contact in case of emergency (Name and Phone): _____

Have you ever been under Chiropractic Care? **Y / N** If so, Who? _____

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? **Y / N** If so, Where? _____

What operations have you had? _____ When? _____

Serious Illness: _____ When? _____

Infectious Diseases: _____ When? _____

Have you had a fall in the past 12 months? **Y / N** If so, When? _____ If so, How many times? _____

Do you have a pacemaker? **Y / N** Have you ever had any Hip or Knee Replacements **Y / N**

What medications or drugs are you taking? (check those that apply): Pain Killers ____ Insulin____

Cholesterol Meds ____ Blood Pressure Meds ____ Muscle Relaxers ____ Birth Control ____ Other: _____

## LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to Superior Spine Care all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. I further understand that my provider may take appropriate and timely action to enforce payment against me for all outstanding medical bills. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Signature of Insured / Guardian Date

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**Patient Name:** _____

**DOB:** _____

**Date:** _____

## SOCIAL HISTORY

**Tobacco use:** ____ Yes ____ No ____ Former Smoker If Yes, how many daily ____
**Alcohol use:** ____ Yes ____ No If yes, how many weekly ____
**Drug use:** ____ Yes ____ No If yes, please explain _____

## REVIEW OF SYSTEMS

It is very important to complete this form. A review of systems is required when you have a Chiropractic / Physical Therapy examination and evaluations. This information is needed for quality of care as many systemic diseases and medical problems may affect your healing process.

**Please "X" if you have recently had any of the following. (Use a "?" if you are not sure)**

### GENERAL

- ☐ Fever
- ☐ Weight loss
- ☐ Weight gain
- ☐ Body aches
- ☐ Cannot sleep
- ☐ Decrease in appetite
- ☐ Cancer: _____

### INTEGUMENTARY

- ☐ Rash
- ☐ Hives
- ☐ Itching
- ☐ Hair loss

### EARS/NOSE/THROAT

- ☐ Hearing loss
- ☐ Ear infections
- ☐ Ears ringing
- ☐ Sinus problems
- ☐ Vertigo

### RESPIRATORY

- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Cough
- ☐ Sleep apnea

### CARDIOVASCULAR

- ☐ Chest pain or pressure
- ☐ Irregular or rapid heartbeat
- ☐ Leg cramps while walking
- ☐ Shortness of breath laying down
- ☐ Swelling or feet/ankles

### GASTROINTESTINAL

- ☐ Heartburn or indigestion
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Pain in the abdomen
- ☐ Hiatal hernia
- ☐ Constipation
- ☐ Crohn's Disease

### RENAL/ URINARY

- ☐ Difficulty urinating
- ☐ Hematuria
- ☐ Kidney stones
- ☐ Urinary incontinence
- ☐ Urgency
- ☐ Prostate enlargement *(men)*

### GYNECOLOGICAL *(women)*

- ☐ Heavy menstrual flow
- ☐ Polycystic Ovary Disease
- ☐ Hot flashes
- ☐ Menopause

### MUSCULOSKELETAL

- ☐ Joint pain/ swelling
- ☐ Fractures: _____
- ☐ Back pain and stiffness
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Muscle pain or cramps

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**DOB:** _____

**Date:** _____

## NEUROLOGICAL

- ☐ Seizures
- ☐ Delayed motor skills
- ☐ Poor balance
- ☐ Confusion
- ☐ Dementia
- ☐ Dizziness
- ☐ Headaches/migraines
- ☐ Numbness
- ☐ Speech delay/ slurred speech
- ☐ Tremors
- ☐ Weakness

## ENDOCRINE

- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Fatigue
- ☐ Hyperactivity
- ☐ Diabetes
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Hormone imbalance

## HEMATOLOGY/LYMPHATIC

- ☐ Swollen lymph nodes
- ☐ Non-Hodgkin's Lymphoma
- ☐ Bleeds easily
- ☐ Bruises easily
- ☐ Lymphedema
- ☐ Blood clotting disorder

## EMOTIONAL

- ☐ ADD/ADHD
- ☐ Anxiety
- ☐ Depression
- ☐ Panic attacks

## ALLERGIES/IMMUNOLOGICAL

- ☐ Seasonal allergies
- ☐ Food allergies:_____
- ☐ Other:_____
- ☐ Other: _____

## EYES

- ☐ Blurred vision
- ☐ Double vision
- ☐ Flashes/floaters

## MEDICATIONS

- ☐ Blood thinners
- ☐ Pain killers
- ☐ Insulin
- ☐ Cholesterol Meds
- ☐ Blood pressure Meds
- ☐ Muscle relaxers
- ☐ Birth control
- ☐ Other:_____

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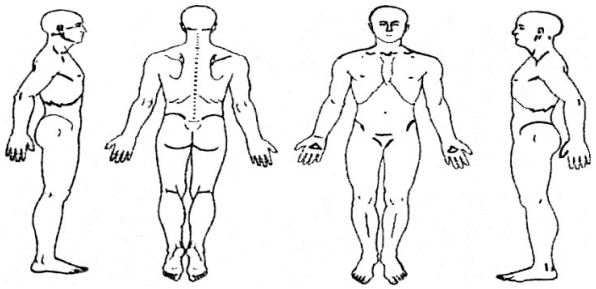
# CASE HISTORY

Name: _____

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

| Condition / Problem | Severity (Minimal – Severe) | Frequency (% of week) (Occasional – Constant) |
|---|---|---|
| a. _____ | 1 2 3 4 5 6 7 8 9 10 | 0 10 20 30 40 50 60 70 80 90 100 |
| b. _____ | 0 1 2 3 4 5 6 7 8 9 10 | 0 10 20 30 40 50 60 70 80 90 100 |
| c. _____ | 0 1 2 3 4 5 6 7 8 9 10 | 0 10 20 30 40 50 60 70 80 90 100 |
| d. _____ | 0 1 2 3 4 5 6 7 8 9 10 | 0 10 20 30 40 50 60 70 80 90 100 |

**(Please mark the figures where you experience pain.)**



2. Symptoms are <u>worse</u> in the (circle what applies)
   - -morning
   - -afternoon
   - -night
   - -Increase during the day
   - -same all day
   - -decrease during the day

3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

5. When did your symptoms begin (onset date)? _____

6. How did your symptoms begin? _____

7. Did these symptoms begin during working hours? ____No ____Yes Describe: _____

8. Are these symptoms related to a recent car accident? ____No ____Yes Describe: _____

9. Have you experienced these before? _____

10. Do your symptoms radiate? _____

11. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began

12. Circle the things that make your problems worse:

    Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping

13. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____

    If No, what have you tried that has not helped? _____

14. Have you been treated for this before? ____No ____Yes How long ago? _____

15. What treatment did you receive? _____

16. Results of previous treatment? ____Good ____Poor Comments _____

17. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation

18. List any other major injuries you have had, other than those mentioned above: _____

19. Any other Musculoskeletal problems? ____No ____Yes …Neurological problems? ____No ____ Yes

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date: _____

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# *Terms of Acceptance*

The goal of our office is to enable patients to gain control of their health. To attain this, we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.
Please read the below and if you have any questions please feel free to ask one of our staff members.

## Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Superior Spine Care, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

## Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care, physical therapy, and massage therapy..

## Communications:

If we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: ____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

## Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____

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# *Cancellation and Credit Card on File Policies*

**Missed/Cancellation of Appointments:**

There is a possible fee charged for all appointments that are not canceled 24 hours prior to scheduled visit. Any appointment that is not canceled 24 hours prior to scheduled appointment will be charged $30.

**Credit Card on File Policy:**

At Superior Spine Care, we require keeping your credit, debit, or HSA/FSA card on file as a convenient method of payment for the portion of services that your insurance does not cover, but which you are liable for. This card will also be used to charge any cancellation fees that you may have. Without this authorization, an "outstanding balance" charge of 1.5 percent of the total bill will be charged for each month that the bill remains unpaid. Furthermore, a billing fee of $35.00 will be charged added to your account for any outstanding account that has a balance for more than 90 days, which are sent to our collection agency.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account. Massage therapy sessions are not processed through insurance and will be charged at end of the business day services are rendered if you do not provide an alternative payment during your appointment.

I authorize Superior Spine Care to charge the portion of my bill that is my financial responsibility to the following card.

☐ Amex ☐ Visa ☐ Mastercard ☐ Discover

Credit Card Number _____

Expiration Date _____

Card Holder Name _____

Signature _____

Security Number (3 digit number on the back of the card) _____

Billing Address _____

_____

I (we), the undersigned, authorize and request Superior Spine Care to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility, and all services that were not paid for on the service date that are not submitted to insurance (massage sessions).

This authorization relates to all payments not covered by my insurance company for services provided to me by Superior Spine Care.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Superior Spine Care in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____ Date: _____ / _____ / _____

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Patient Name: _____

Date: _____

# Superior Spine Care Financial Policy

We sincerely wish to provide the best possible medical care. This involves mutual understanding between the patients, doctors, and staff. We encourage you, our patient, to discuss any questions you may have regarding this payment policy.

Payment is expected at the time of your visit for services not covered by your insurance plan. We will do our best to estimate the amount of the visit for you, but due to vast changes among insurance plans, you may have an additional balance once your insurance sends payments. We accept cash, check, HSA/FSA cards, and credit / debit cards.

Credit will be extended as necessary, and only after request of the patient, and approval of the Office Manager.

## Credit Policy

Requirements for maintaining your account in good standing are as follows:

1. All time of service payments are due at the beginning of your visit. These are previous balances, copayments, coinsurance, noncovered fees, charges of nonparticipating providers, charges for self-pay patients, deductibles, or cancellation fees.
2. All other charges are due and payable within 30 days of the first billing.
3. For services not covered by your health plan, payment at the time of services is necessary.
4. If other circumstances warrant an extended payment plan, our Office Manager will assist you in these special circumstances at your request.
5. Failure to stay in good credit standing with our practice can result in the refusal of services from our providers.
6. An "outstanding balance" charge of 1.5 percent of the total bill will be charged for each month that the bill remains unpaid. Furthermore, a billing fee of $35.00 will be charged added to your account for any outstanding account that has a balance for more than 90 days, which are sent to our collection agency.

An itemized statement of all medical services will be mailed or emailed to you every 30 days. We will prepare and file your claims to the health plan. If further information is needed, we will provide any additional information.

## Insurance

Unless we have contracted directly with your health plan, we cannot accept the responsibility of negotiating claims. You, the patient, are responsible for payment of medical care regardless of the status of the medical claim. You should contact your insurance provider to verify your visit with the scheduled provider will be covered by your policy. Some health plans do require referrals from your primary care physician. Failure to do so may result in your insurance plan denying your claim, leaving you responsible for all associated costs. It is your responsibility to obtain these referrals and bring them to the office. In situations where a claim is pending or when treatment will be over an extended period of time, we will recommend that a payment plan be initiated. Your health plan is a contract between you and your insurance company. We cannot guarantee the payment of your claims. If your insurance company pays only a portion of the bill or denies a claim, any contact or explanation should be made to you, the policyholder. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred.

## Insufficient Funds Payment Policy

We will charge an insufficient funds processing fee for all returned checks and credit / debit charge backs. If your payment is dishonored, we may electronically debit your account for the payment, plus insufficient funds processing fee of $35. If you bank account is not debited, the returned check amount (plus $35 fee) must be paid via cash or credit. We will not accept money orders or cashier's checks.

**I have read and fully understand the above statements. I have reviewed the financial policy and understand I am responsible to pay for services rendered. I also acknowledge if my account does become outstanding, my account may be sent to collections. Upon request I will be given a copy.**

Patient Name (Print): _____

Patient Signature: _____ Date: _____ / _____ / _____