PROGRESSIVE
SPINE & REHAB CENTER

Get better faster-
Stay better longer.

WELCOME!!

Thank you for selecting our office.
To help us meet all your healthcare needs, please fill out this form completely.
If you have any questions or need assistance, please ask us – we will be happy to help.

Patient Information (CONFIDENTIAL)

First Name _____ Middle _____ Last _____

Birthdate____/____/_____Age_____ Social Security# _____

Address _____

City _____ State ____ Zip _____

*Phone #(C / H)_____ ****E-mail**_____*

Gender at birth: M___ F___ Pronouns_____/_____ Marital Status: S M W D

Employer _____ Job Title _____

Emergency Contact _____ Phone _____

***Family Physician** _____Last Physical Exam?_____*

***How did you hear about us?**_____*

***What is your primary complaint?** _____*

IS THIS WORKERS COMPENSATION? _____ IS THIS PERSONAL INJURY?_____

Insurance Information

Name of Insured_____Relation to Patient _____

Birthdate ____/____/_____Social Security # _____ Phone # _____

Address_____City_____State____Zip_____

Name of Employer _____ Work Phone _____

Insurance Co._____Group # _____Policy # _____

**Your Email usage includes, but is not limited to, general office communications, appointment reminders, and office newsletter. We will never communicate your PHI via email. ☐ Opt In ☐ Opt out*

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Patient Initials_____

Returning Patients: Is this a **NEW** Complaint? Y / N **

Primary Complaint?_____
Location: __Head __Neck __Shoulder __Arm __Mid back
__Low back __buttock __Leg Other_____

History of Present Illness:
Date of onset?_____ Work related? Yes/No
What caused the onset?_____
_____

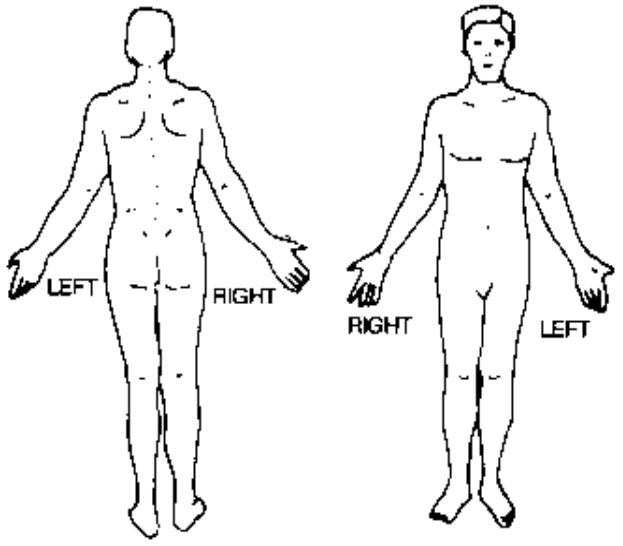
Is your Condition: ___Constant ___Intermittent
___Frequent ___Occasional ___Changing

Have you had a similar episode before? __Yes __No

Over the past WEEKS/MONTHS has yourcondition:
__Improved __Worsened __Not changed

How would you rate your pain right now?
None 0 1 2 3 4 5 6 7 8 9 10 Most Severe

Please mark your discomfort:



How do the following affect your condition?

	Worse	Better	No Change
Cough/sneeze	_____	_____	_____
Sitting	_____	_____	_____
Standing (rising)	_____	_____	_____
Walking/Running	_____	_____	_____
Up/down Stairs	_____	_____	_____
Bending fwd/back	_____	_____	_____
Twisting	_____	_____	_____
Lifting	_____	_____	_____
Reaching/Grasping	_____	_____	_____
Lying on back	_____	_____	_____
Lying on stomach	_____	_____	_____
Lying on side (R/L)	_____	_____	_____
Rolling over in bed	_____	_____	_____
Looking up/down	_____	_____	_____
Turning head R/L	_____	_____	_____
AM/PM/Daytime	_____	_____	_____
Warmth/Cold	_____	_____	_____
Stretching	_____	_____	_____

How would you best describe your pain/symptom?

Sharp	Ache	Stabbing	Pins & Needles
Dull	Burn	Stinging	Numbness
Stiff	Tight	Radiating	

Prior treatment(s) for your complaint?
Medication_____
Steroid / Injection_____
Surgery_____
Physical Therapy_____
Chiropractic_____
Massage_____
MRI / X-Ray / CT Scan_____

Does your condition wake you from sleep? Y / N

What **activities** are impeded by your complaint?
1. _____
2. _____
3. _____
4. _____

What can **you** do to make your complaint better?
_____
_____

Does your complaint bother you at work? Y / N
___Computer ___Driving ___Pushing
___Sitting ___Carrying ___Pulling
___Travel ___Phone ___

What are your goals regarding treatment:

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Patient Initials_____

Review of Systems: (Please check symptoms you are experiencing **related to your primary complaint**)

Constitutional: ___Weight change ___Fever ___Chills ___Night Sweats ___Weakness/Fatigue
Eyes: ___Vision problem ___Pain ___Discharge
Ears, Mouth, and Throat: ___Hearing problem ___Ringing ___Pain ___Discharge ___Bleeding
___Difficulty swallowing ___Sore throat ___Change in taste
Skin: ___Rash ___Itching ___Hair changes ___Nail changes
Neurologic: ___Headaches ___Dizziness___Fainting ___Convulsions
Gastrointestinal: ___Appetite change___Stomach pain ___Vomiting ___Diarrhea___Constipation
Genitourinary: ___Frequent urination ___Painful urination ___Incontinence
Cardiovascular: ___Chest Pain ___Palpitations ___Difficulty breathing ___Coughing
___Wheezing ___Blue extremities ___Swollen extremities
Psychosocial: ___Anxiety issues ___Depression ___Moods ___Memory
Breasts (Female only): ___Masses ___Pain ___Discharge
Infection (recent): ___Urinary tract ___Respiratory ___Skin ___Other: _____

Family Medical History:

Has anyone in your family (Parents, Siblings) experienced any of the following?
___Heart disease ___Cancer ___Stroke ___Diabetes ___Arthritis ___High Blood Pressure
___Muscle disease ___Fibromyalgia ___Auto-Immune ___Alzheimer's/Dementia ___Asthma
Other_____

Past Medical History:

Please place a checkmark by the condition that applies to **you**:
___Heart disease ___Cancer ___Arthritis ___Alcoholism___Osteoporosis (penia)
___High Cholesterol ___Diabetes ___Kidney disease ___Seizures ___Lung Disease ___Concussion
___High BP ___Obesity ___Thyroid disease ___Ulcers ___AIDS/HIV ___Hepatitis
___Stroke ___IBS Issues ___Depression ___Anxiety ___Joint Replacement

Other_____

Surgeries/Hospitalizations: Injuries/Fractures/Dislocations:

(Please list all that apply)
_____Year:_____ _____Year:_____
_____Year:_____ _____Year:_____

Please list ALL of the medications/supplements you are currently taking:

_____
_____

Drug or Other Allergies:YES / NO if YES, please list: _____

Do you have a pacemaker? YES / NO Are you pregnant? YES / NO / N/A (Due date:_____)
Do you think you may become pregnant? YES / NO

LifestyleHabits:

- Tobacco_____(# of cigarettes/day)
- Alcohol_____(# of drinks/week)
- Sleep_____(#hours/day)
- Water_____(#/day)
- Frequency of exercise: Never Daily Weekly Monthly
- How many times in D/W/M? _____
- What form of exercise do you prefer?_____
- **Has your condition prevented you from exercising? Y / N**

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HIPAA Patient Consent Form

In this document, “I” and “my” refer to the patient,“chiropractor” refers to PSRC.

We are required by the Health Insurance Portability and Accountability act of 1996 (HIPPA) to maintain the privacy or your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI. You have the right to review our Notice of Privacy Practices before signing this consent and you are encouraged to do so.

By signing this form, I consent to the use and disclosure to third parties of my PHI by chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of chiropractor. I understand that analysis, diagnosis or treatment of me by chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if chiropractor agrees to a restriction that I request, the restriction is binding on chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have a right to review the Notice of Privacy Practices of chiropractor prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of chiropractor.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

X_____ **X**_____

Signature of Patient or Responsible Party: **Date:**

X_____

Printed Name

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Informed Consent for Chiropractic Treatment

To the Patient: *Please read this entire document prior to signing. It is important you understand the information enclosed. Please ask questions before you sign if there is anything unclear.*

Chiropractic is a form of health care used to manage a wide variety of conditions including acute injury, chronic pain and disability – all related to spinal restrictions. As part of the analysis, examination and treatment, you are consenting to the following procedures: vital signs, orthopedic testing, range of motion, basic neurologic testing, muscle strength, postural analysis, functional movement evaluation, spinal manipulation, manual therapy, dry needling, therapeutic exercises, massage, and therapeutic modalities. The goal of such treatment is to accelerate recovery of ailment(s) and aid in achieving maximal functional capacity. All procedures will be thoroughly explained to you before you are asked to perform them.

The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor. It is your right to decline any part of your treatment at any time.

Response to chiropractic intervention varies from person to person; hence, it is not possible to accurately predict your response to treatment. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: stiffness, soreness, fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination. Stroke and /or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

Other treatment options for your condition may include: • Self-administered, over-the-counter analgesics and rest • Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers • Hospitalization • Surgery. If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician. Remaining untreated also has risks and benefits specific to the condition you are experiencing. Generally, leaving an injury untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I have read, or have had read to me, the above explanation of chiropractic manipulation and related treatment(s). I understand I will have opportunities to discuss the information contained herein, with any questions I have being answered to my satisfaction, prior to beginning treatment. I understand I have the right to deny any part of treatment recommended to me at any time. By signing below I state that I have weighed the risks involved as explained herein, and have decided to undergo treatment. Having been informed of the risks, I hereby give my consent to treatment or treatment of my minor dependent.

_____ _____

Patient or Parent Signature: **Date:**

_____

Printed Name:

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Financial Agreement

Please know, payment of your bill is considered part of your treatment. The following is a statement of our Financial Agreement which we require you to read and sign prior to any treatment.

➜ PAYMENT: DUE AT TIME SERVICES ARE RENDERED in accordance with applicable insurance plan. **If patient has a deductible which is not met, a down payment of $50 is required.**

➜ PAYMENT METHODS: Cash, Check, Credit Card (Visa, MC), HSA or FSA, and Patient Financing options for those who are credit worthy. ChiroHealth USA available to patients who are underinsured or uninsured. Letter of protection with signed lien acceptable when working with attorney.

➜ COLLECTIONS: A maximum of 3, monthly statements will be sent to patient's address on file indicating an outstanding balance. Unless working with an attorney, VA or Workers Compensation, an outstanding balance not paid within 90 days is reported to a collection agency. In the event patient's account is turned over for collections, patient agrees to pay all additional fees accessed in the collection of the debt. These fees include, but are not limited to, collection fees and attorney fees.

➜ CANCELLED APPOINTMENTS, NO-SHOWS: Please cancel appointment 24+ hours in advance. Failure to do so will result in a $40 charge for missed appointments. This fee is not billable to insurance.

➜ INSURANCE: PSRC *strongly* recommends patient contact their insurance company to get information on chiropractic coverage. PSRC will obtain available chiropractic coverage information from patient's insurance company for the purpose of accurate billing and review this with patient. If required by insurance carrier, IT IS PATIENT'S RESPONSIBILITY TO OBTAIN REFERRAL and/or AUTHORIZATION FROM A PRIMARY CARE PHYSICIAN (PCP).

➜ INSURANCE: All claims will be submitted to patient's PRIMARY insurance company on a weekly basis. Although PSRC is billing patient's insurance company, not every service is covered. Any remaining BALANCE IN FULL is patient's responsibility. **Patient agrees to assume full financial responsibility on all charges in excess, denied, are deemed "non-covered, and/or "not patient responsibility" by health or PI insurance, workers' compensation or Medicare plans.**

➜ INSURANCE: Patient is responsible to notify PSRC of changes to insurance coverage or, if applicable, changes to attorney. Failure to do so, resulting in denial of billed claims will result in patient being responsible for the entirety of outstanding balance.

➜ CHECKS: Returned checks are assessed a $25.00 non-sufficient funds charge in addition to outstanding bill. Checks not paid within 2 weeks of being returned to PSRC will be reported to the local district attorney's office.

➜ If you are pursuing legal action for the injuries/conditions for which we are treating, this agreement provides a Letter Of Protection ensuring that any proceeds recovered from the disposition of that legal action will be applied against any outstanding balance owed to Progressive Spine & Rehab Center.

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Authorization is granted for payment directly to PSRC, of all group or individual insurance benefits payable as a result of treatment. Authorization is also granted to PSRC to release information pertaining to my treatment to the payor or its representatives via fax, phone, paper or electronically. 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 in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions

I have read, understand, and agree to the above financial policy for payments of professional fees. This agreement will remain in effect until revoked by me in writing.

X_____ X_____

Signature of Patient or Responsible Party **Date**

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Patient Name: **DOB:**

Insurance Company:

Notice of Insurance Coverage

Your insurance does not cover all chiropractic services. While we do our best to verify your insurance covers chiropractic, we cannot verify coverage of every treatment code which may be used in your plan of care. Below is a list of services usually expected to be covered and what may NOT be covered. Services rendered, regardless of insurance coverage or not, are done so with reasonable expectation of reimbursement either by your insurance or by you directly.

Usually covered services	Services which may NOT be covered
☐ Initial Evaluation (99202-04) ☐ Spinal Manipulation (98940-42)	☐ Re-Evaluation (99212-14) ☐ Extremity Manipulation (98943) ☐ Therapeutic Exercise (97110) ☐ Dry Needling (20560-1) ☐ Manual Therapy (97140) ☐ Decompression (S9090) ☐ Ultrasound (97035) ☐ E-Stim (97014) ☐ Infrared Light (97026) ☐ Orthotics Inserts

Responsibility for Payment of Services

By signing below, I acknowledge and agree that I am responsible for paying for rendered services in any of the following circumstances:

- If the procedure is not covered under my insurance plan, i.e., it is not listed as a “Covered Service” in the Certificate of Coverage issued by my insurer;
- If, after billing my insurance carrier for the performed procedure, the claim line denial indicates the procedure is “non-covered” and/or “not patient responsibility;”
- If my insurance determines the procedure is not “medically necessary” as defined in my insurance plan documents, even though it may not be on the list of non-covered services;
- If my insurance determines the procedure is “investigational and/or experimental” and not a “Covered Service;”
- If I have not changed my primary care provider (“PCP”) to current PCP, i.e., valid PCP not on file and/or missing;
- If my insurance has changed and therefore am not covered under the insurance plan on file.

Note: All services provided, whether covered or non-covered, will be thoroughly explained prior to application, taking care to address your questions and concerns (including cost).

X_____ X_____

Signature of Patient or Responsible Party **Date**

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OPTIONAL

DRY NEEDLING CONSENT AND INFORMATION FORM

To the patient: *Please read this entire document prior to signing. It is important you understand the information enclosed. You have the right to withdraw consent for this procedure at any time.*

Dry Needling involves inserting a tiny monofilament needle in a muscle or muscles in order to release shortened bands of muscles and decrease trigger point activity. This can help resolve pain and muscle tension, and will promote healing. This is not traditional Chinese Acupuncture, but is instead a medical treatment that relies on a medical diagnosis to be effective. Dry Needling is a valuable and effective treatment for musculoskeletal pain. Like any treatment, there are possible complications. While complications are rare in occurrence, they are real and must be considered prior to giving consent for treatment.

Risks: The most serious risk with Dry Needling is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe puncture can require hospitalization and re-inflation of the lung. This is a rare complication, and in skilled hands it should not be a major concern. Other risks include injury to a blood vessel causing a bruise, infection, and/or nerve injury. Bruising is a common occurrence and should not be a concern.

Patient's Consent: I understand that no guarantee or assurance has been made as to the results of this procedure and that it may not cure my condition. My therapist has also discussed with me the probability of success of this procedure, as well as the probability of serious side effects. Multiple treatment sessions may be required/needed, thus this consent will cover this treatment as well as consecutive treatments by this facility. I have read and fully understand this consent form and understand that I should not sign this form until all items, including my questions, have been explained or answered to my satisfaction. With my signature, I hereby consent to the performance of this procedure. I also consent to any measures necessary to correct complications which may result.

Please answer the following questions:

1. Are you pregnant or think you may become pregnant? ☐ Yes ☐ No
2. Do you have a pacemaker or other electrical implants? ☐ Yes ☐ No
3. Are you currently taking anticoagulants (ex: Aspirin, blood thinners)? ☐ Yes ☐ No
4. Are you currently taking antibiotics for an infection? ☐ Yes ☐ No
5. Do you have a damaged heart valve or other risk of infection? ☐ Yes ☐ No
6. Do you suffer from metal allergies? ☐ Yes ☐ No
7. Are you a diabetic or do you suffer from impaired wound healing? ☐ Yes ☐ No
8. Have you undergone surgery or an implant within the past 4 months? ☐ Yes ☐ No
9. Do you have Hepatitis B, C, HIV, or any other infectious disease? ☐ Yes ☐ No

**** There is an additional $35 charge for Dry Needling as this is a not covered by Insurance. ****

_____ _____

Signature **Date**

_____ _____

Print Name **Relationship to patient (if other than patient)**