Fair Chiropractic

EIN: 46-2406598

2305 S. Kansas., Ste. 104, Newton, KS. 67114

Patient Information **Date:** _____

Name: _____ DOB: _____

Sex: □ Male □ Female

Marital Status: □ Married □ Single □ Widowed □ Divorced □ Partnered □ Separated □ Minor

Cell Phone: _____ □ Opt In to text reminders

(Standard data and messaging rates may apply)

Alternate Phone: _____ □ Work □ Home □ _____

Address: _____ Apartment #:_____

City: _____ State: _____ Zip: _____

Email Address: _____ □ Opt In to our occasional newsletter for specials, deals and updates

Occupation: _____ Employer: _____

□ Full-time □ Part-time □ Retired

Spouse Name: _____ Spouse DOB: _____

Spouse Employer: _____

How did you hear about our office?

□ Internet Search □ Facebook □ Instagram □ Location (Driving By) □ Mailer

□ Family: _____ □Friend: _____

□ Any family members in need of spinal exam?: _____ □ Other: _____

Insurance Information ☐ **Personal/Health Care** ☐ **3rd Party** ☐ **Self-Pay**

Primary

Insurance Carrier: _____ ID#: _____ Group #: _____

Insurance Phone Number: _____ Name of Primary Insured: _____

Address: _____ DOB: _____ Relationship to patient: _____

Secondary

Insurance Carrier: _____ ID#: _____ Group #: _____

Insurance Phone Number: _____ Name of Primary Insured: _____

Address: _____ DOB: _____ Relationship to patient: _____

□ Third Party □ Auto □ Work Comp □ Personal Injury

Claim #:_____ Claim Contact: _____ Claim Phone #: _____

Attorney Name: _____ Attorney Phone #: _____

A. Notifier: Fair Chiropractic 2305 S. Kansas Ave. Ste 104 Newton KS 67114 NPI1790962223

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Exam	Non Covered Service	$20-30
X-Ray	Non Covered Service	$35.00
Decompression	Non Covered Service	$20.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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Practice's Requirements

The Practice

A. Is required by federal law to maintain the privacy of your protected health information (PHI) and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
B. Under the privacy rule, may be required by State Law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.
C. Is required to abide by the terms of this Privacy Notice.
D. Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
E. Will distribute any revised Privacy Notice to your prior implementation.
F. Will not retaliate against you for filing a complaint.

Effective Date

This notice is in effect as of 6/1/2010.

Patient acknowledgement

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

_____ _____

Patient Signature Date

Informed Consent

_____ **Initial** on the line provided if you agree to consent to the initial examinations – consultation, physical examination, and radiographic (x-ray) examination – as the doctors see fit.

_____**Initial** on the line provided if you agree to consent to the following treatments and therapies – chiropractic adjustment, electrical muscle stimulation, roller bed, decompression, stretching and strengthening recommendations – as the doctors see fit.

I verify that the above information that has been provided is true, accurate, and given in full to the best of my knowledge. I understand the risks, benefits and alternatives associated with the examination and treatment of the above initialed items. I give informed consent to receive the examinations and treatments as the doctors see fit. I understand that this consent can be revoked at any time.

_____ _____

Patient Signature Date

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Initial Patient Evaluation and Financial Disclaimer

By signing my name below, I express my understanding that…

1. Services for my initial visit at Fair Chiropractic will include a complete consultation, full body examination and x-rays if deemed necessary.
    a. No treatment is included with these services.

2. Chiropractic treatment, my exam results and x-ray results (if any were taken) will be provided during my Report of Findings visit.

3. Payment is due at the time of service. Fair Chiropractic has a $0.00 balance policy.
    a. As a patient who chooses to utilize my chiropractic insurance benefits, I am responsible for what insurance will not cover. I am responsible for any other charges on my account. An employee of Fair Chiropractic is available to me to discuss my insurance benefits, my financial options as well as the charges on my account.

    OR

    b. As a "self-pay" patient, I am responsible for all costs of services and any other charges on my account. An employee of Fair Chiropractic is available to me to discuss my financial options as well as the charges on my account.

_____ _____

Patient Signature Date

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Health History

Patient Name: _____ Date: _____

What type of regular exercise do you preform? □ None □ Light □ Moderate □ Strenuous

What is your height and weight? Height: _____ Weight: _____lbs.

For each of the conditions listed below, place a check in the box if you have experienced any of them

Musculoskeletal
- □Arthritis
- □Cramping
- □Elbow/Wrist Pain
- □Foot/Ankle Pain
- □Gout
- □Hip Disorders
- □Knee Injuries
- □Osteoporosis
- □Pins or Screws
- □Scoliosis
- □Shoulder Problems
- □Weak Muscles

Neurological
- □Anxiety/ Depression
- □Dizziness
- □Epilepsy or Seizures
- □Loss of Smell or Taste
- □Memory Issues
- □Numbness
- □Sleeping Issues
- □Stroke
- □Temporary Loss of Vision, or Hearing

Head/ENT
- □Blurred/Double Vision
- □Cataracts
- □Chronic Ear Infection
- □Dental Problems
- □Difficulty Swallowing
- □Eye/Vision Problems
- □Headaches/Migraines
- □Sinus Trouble
- □Ringing in the Ears
- □Swollen Lymph Nodes
- □TMJ Problems

Cardiovascular
- □Blood Clots
- □Chest Pain/Tightness
- □Heart Disease
- □Heart Murmur
- □High Blood Pressure
- □High Cholesterol
- □Low Blood Pressure
- □Palpitation
- □Rheumatic Fever
- □Swollen Legs/Feet
- □Varicose Veins

Respiratory
- □Apnea
- □Asthma
- □Emphysema
- □Pneumonia
- □Shortness of Breath
- □Tuberculosis
- □Wheezing

Gastrointestinal
- □Irregular Bowel Movements
- □Colon Cancer
- □Crohn's Disease
- □Heartburn
- □Hemorrhoids
- □I.B.S
- □Liver Disease
- □Nausea/Vomiting
- □Pancreatitis
- □Ulcer

Genitourinary
- □Blood in Urine
- □Incontinence
- □Kidney Problems
- □Sexual Dysfunction
- □Urinary Infections

Endocrine
- □Cushing's Syndrome
- □Diabetes
- □Excessive Thirst
- □Heat/Cold Intolerance
- □Thyroid Problems
- □Increased Urination
- □Pancreatic Conditions

Derma/Hemo
- □Change in Hair/Nails
- □Easy Bruising
- □Eczema/Rash
- □Gum Bleeding
- □Psoriasis
- □Skin Cancer

Illnesses
- □Hepatitis
- □Anorexia/Bulimia
- □Anemia
- □AIDS/HIV
- □Hernia
- □Pacemaker
- □Miscarriage
- □Prostate Problems
- □Psychiatric Care
- □Suicide Attempt
- □Other:_____
- _____
- _____
- _____

Indicate if an immediate family member has had any of the following:

□Rheumatoid Arthritis □Heart Problems □Diabetes □Cancer □Scoliosis □ _____

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Social History

Patient Name: _____ Date: _____

Alcohol: □Daily □Weekly □Occasionally □Never □ Quit

Tobacco: □Daily □Weekly □Occasionally □Never □ Quit

Intake Method: □ Cigarettes □ Electronic Cigarettes/Vaporizers □Chew

How Much? _____

Recreational Drugs: □Daily □Weekly □Occasionally □Never □ Quit

Caffeine: □Daily □Weekly □Occasionally □Never □ Quit

Soft Drinks: □Daily □Weekly □Occasionally □Never □ Quit

Female Patients Only: Are you Pregnant? □No □ Yes - Due Date: _____

Medications (Over the Counter and Prescription) _____

_____

_____

_____

Vitamins, Herbs, Minerals: _____

_____

Allergies: _____ □ Seasonal Allergies

Injuries and Surgeries

Please notate the area effected or injured if applicable as well as the approximate corresponding date

Broken Bones _____

_____

Date(s): _____

Dislocations_____

_____

Date(s): _____

Falls_____

_____

Date(s): _____

Head Injuries _____

_____

Date(s): _____

Surgeries

1) _____

Date: _____

2)_____

Date: _____

3)_____

Date: _____

4) _____

Date: _____

Other _____

_____

_____

Date(s): _____

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Patient Name: _____ **Date:** _____

Problem Area 1 *Please Describe the Problem Area and Symptoms*:

_____

Approximate Start Date: _____ **How did this happen?** _____

What best matches the description of your symptoms? □ Sharp □ Dull □ Numb □ Shooting □ Burning □ Tingling □ Achy

How would you rate your pain?
Please Circle the Corresponding Number

No Pain — Mild — Moderate — Severe — Unbearable
0 1 2 3 4 5 6 7 8 9 10

How often during the day do you experience these symptoms?
Please Mark on the Scale the Approximate Percentage

Never — Half of The Day — All Day
0% 25% 50% 75% 100%

Problem Area 2 *Please Describe the Problem Area and Symptoms*:

_____

Approximate Start Date: _____ **How did this happen?** _____

What best matches the description of your symptoms? □ Sharp □ Dull □ Numb □ Shooting □ Burning □ Tingling □ Achy

How would you rate your pain?
Please Circle the Corresponding Number

No Pain — Mild — Moderate — Severe — Unbearable
0 1 2 3 4 5 6 7 8 9 10

How often during the day do you experience these symptoms?
Please Mark on the Scale the Approximate Percentage

Never — Half of The Day — All Day
0% 25% 50% 75% 100%

Area below is for office use only.

		L	R
Biceps	C5		
Brachial	C6		
Triceps	C7		
Patellar	L4		

C-Flex	60	_____	M M S
C-Ext	50	_____	M M S
C-L/Rot	80	_____	M M S
C-R/Rot	80	_____	M M S
C-L/LB	40	_____	M M S
C-R/LB	40	_____	M M S
L-Flex	90	_____	M M S
L-Ext	30	_____	M M S
L-L/LB	35	_____	M M S
L-R/LB	35	_____	M M S
L-L Rot	30	_____	M M S
L-R Rot	30	_____	M M S

	W	L	R	W
Max Cervical Comp.	___	___	___	___
Jackson's Comp.	___	___	___	___
Grip Strength		___	___	

	L	R
Posture Low Head		
Posture Low Shoulder		
Posture Lowside Hips		
Head Carriage	Anterior / Normal	
Kyphosis	Hyper / Norm / Hypo	
Lordosis	Hyper / Norm / Hypo	
Adam's Sign		
Kemp's Test		

R	L/R	L/R	R
	L	R	
Straight Leg Raiser			

Gaenslens Test		
Patrick Fabere		
Milgram's		
Soto Hall		
George's Test		
Short Leg		
Nachlas		
Elys		
Lewins		

		PAIN L	SPASM L	SPASM R	PAIN R
C	1				
	2				
	3				
	4				
	5				
	6				
	7				
T	1				
	2				
	3				
	4				
	5				
	6				
	7				
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	9				
	10				
	11				
	12				
L	1				
	2				
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	4				
	5				
S					
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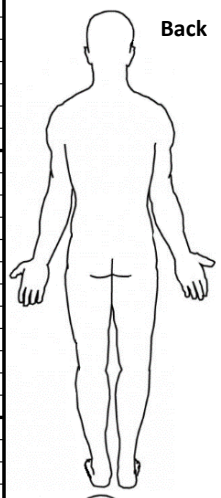

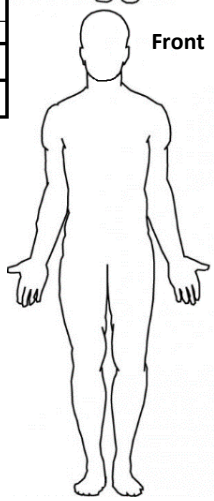

HEADACHE

Where? _____

Pain? _____

Aura? _____

Often? _____

Notes _____

Notes: _____

X-Ray Reason				
	Osteoporosis	Trauma	Spondylo	3 Months +
	Potential Disc	Arthritis	Unresp. To Prev. Chiro.	
	Curvature	Other: _____		

PH: _____ Adrenal: _____ X-ray: _____

DX CODES

1 _____ 3 _____ 5 _____ 7 _____

2 _____ 4 _____ 6 _____ 8 _____

_____

Signature

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Patient Name: _____ Date:_____

How has your condition changed since its onset?

□ Improved □ Stayed the same □ Worsened

What aggravates this condition? Please mark all that apply

Neck	Low Back	Mid-Back
□ Using a Computer	□ Getting in and out of Cars	□ Dressing
□ Concentrating	□ Getting in and out of Bed	□ Showering
□ Holding Head Still	□ Moving from Sitting to Standing	□ Getting out of Bed
□ Driving a Car	□ Walking/Exercising	□ Brushing Hair/Teeth
□ Dressing	□ Climbing Stairs	□ Washing Dishes
□ Washing Hair	□ Mowing Lawn/Yard Work	□ Gardening
□ Brushing Teeth	□ Twisting/Squatting	□ Yard work
□ Yard Work	□ Standing more than 10 minutes	□ Driving
□ Exercise	□ Sitting more than 10 minutes	□ Sitting Still
□ Working	□ Shopping	□ Computer Work
□ Washing Dishes	□ Balance	□ Shopping
□ Lifting	□ Lifting Objects	□ Lifting more than 10lbs
□ Pain with Sleeping	□ Doing Dishes/Vacuuming	□ Vacuuming
□ Grip Strength	□ Stooping/Bending Over	□ Caring for Family
□ Cooking	□ Normal Job Activities	□ Cooking
□ Pulling	□ Getting Dressed	□ Pulling
□ Pushing	□ Caring for a Family Member	□ Pushing
□ Reaching	□ Sleeping Pain	□ Reaching
□ Talking on the Phone	□ Cooking	

If other, explain: _____

What improves this condition?

□ Nothing	□ Massage	□ Chiropractic Adjustments
□ Cold/Hot Packs	□ Medications	□ Re-directing Attention
□ Exercise	□ Physical Therapy	□ Work
□ Rest	□ Stretching	□ Other

If other, explain: _____

What treatments have you received for this condition up to now?

□ None	□ Physical Therapy	□ Homeopathic Medicine
□ Acupuncture	□ Medications	□ Cortisone Shot
□ Chiropractic Care	□ Massage	□ Other

If other, explain: _____