

Fair Chiropractic

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

EIN: 46-2406598

Patient Information	Date:
Name: _____	DOB: _____
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered <input type="checkbox"/> Separated <input type="checkbox"/> Minor	
Cell Phone: _____	<input type="checkbox"/> Opt In to text reminders (Standard data and messaging rates may apply)
Alternate Phone: _____	<input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> _____
Address: _____	Apartment #: _____
City: _____ State: _____	Zip: _____
Email Address: _____	<input type="checkbox"/> Opt In to our occasional newsletter for specials, deals and updates
Occupation: _____	Employer: _____
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired	
Spouse Name: _____	Spouse DOB: _____
Spouse Employer: _____	

How did you hear about our office?
<input type="checkbox"/> Internet Search <input type="checkbox"/> Facebook <input type="checkbox"/> Instagram <input type="checkbox"/> Location (Driving By) <input type="checkbox"/> Mailer
<input type="checkbox"/> Family: _____ <input type="checkbox"/> Friend: _____
<input type="checkbox"/> Any family members in need of spinal exam?: _____ <input type="checkbox"/> Other: _____

Insurance Information	<input type="checkbox"/> Personal/Health Care <input type="checkbox"/> 3 rd Party <input type="checkbox"/> 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: _____
<input type="checkbox"/> Third Party <input type="checkbox"/> Auto <input type="checkbox"/> Work Comp <input type="checkbox"/> Personal Injury	
Claim #: _____	Claim Contact: _____ Claim Phone #: _____
Attorney Name: _____	Attorney Phone #: _____

A. Notifier: Fair Chiropractic

B. Patient Name:

C. Identification Number:

Advance Beneficiary Notice of Non-coverage (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	\$20-55
X-Ray	Non Covered Service	\$20-70
Decompression	Non Covered Service	\$20
Massage	Non Covered Service	\$35-100

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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CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

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 _____

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

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
- _____

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): _____

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
- Concentrating
- Holding Head Still
- Driving a Car
- Dressing
- Washing Hair
- Brushing Teeth
- Yard Work
- Exercise
- Working
- Washing Dishes
- Lifting
- Pain with Sleeping
- Grip Strength
- Cooking
- Pulling
- Pushing
- Reaching
- Talking on the Phone

- Getting in and out of Cars
- Getting in and out of Bed
- Moving from Sitting to Standing
- Walking/Exercising
- Climbing Stairs
- Mowing Lawn/Yard Work
- Twisting/Squatting
- Standing more than 10 minutes
- Sitting more than 10 minutes
- Shopping
- Balance
- Lifting Objects
- Doing Dishes/Vacuuming
- Stooping/Bending Over
- Normal Job Activities
- Getting Dressed
- Caring for a Family Member
- Sleeping Pain
- Cooking

- Dressing
- Showering
- Getting out of Bed
- Brushing Hair/Teeth
- Washing Dishes
- Gardening
- Yard work
- Driving
- Sitting Still
- Computer Work
- Shopping
- Lifting more than 10lbs
- Vacuuming
- Caring for Family
- Cooking
- Pulling
- Pushing
- Reaching

If other, explain: _____

What improves this condition?

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

If other, explain: _____

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

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

If other, explain: _____