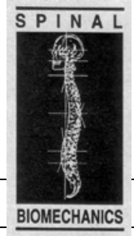
Bailey Chiropractic



9500 Brooktree Rd. Suite 305, Wexford, PA 15090
724 – 934 – 0899

PATIENT INFORMATION

Date______________________________

☐Mr. ☐Mrs. ☐ Ms. ____
(First) (Initial) (Last) (Nickname)

Address ____

City__________________________ State__________ Zip_______ Birthday___________ Age:______ ☐ Male ☐ Female

Employer ____Occupation _______________________________________

Address ____ City___________________ State___________ Zip________

Insurance Company____

Is patient covered by **Spouse's** insurance? ☐ No ☐ Yes Is patient covered by additional insurance? ☐ No ☐ Yes

Subscriber Name ____ Birthday___________________
(First) (Initial) (Last)

Employer_____________________________________ Insurance Company____________________________________

Please present insurance card(s) so we can put a copy in your file.

CONTACT INFORMATION

Best way to reach you ☐ Home ☐ Cell ☐ Work ☐ Email **Home phone** ___________________________

Cell phone ____________________Work phone ____________________ Ext _____ Email____________________________

In Case of Emergency

Name_______________________________ Relationship___________ Home Phone _______________ Cell______________

How did you hear about our office? ☐ Advertisement ☐ Friend ☐ Family Member ☐ Doctor ☐ Other ______________

Is your present pain due to an injury? ☐ No ☐ Yes ☐ On the job ☐ Auto Accident ☐ Other____________________

Has the accident been reported? ☐ No ☐ Yes ☐ To Employer ☐ Workmen's s Compensation ☐Auto Carrier

☐ Other________________

Have you had any surgeries? ☐ No ☐ Yes If yes please list below

Surgery	Date
Surgery	Date
Surgery	Date

X-Ray Exam ☐ No ☐ Yes	MRI ☐ No ☐ Yes	CAT SCAN ☐ No ☐ Yes
When ________________________	When __________________________	When __________________________

PLEASE LIST ANY ACCIDENTS OR FALLS		DATES
Auto	☐ No ☐ Yes	
Sports or Other	☐ No ☐ Yes	
Other	☐ No ☐ Yes	
Broken Bones or dislocations (fractures)	☐ No ☐ Yes	
Have you ever had any spinal taps or spinal injections?	☐ No ☐ Yes	
Were you ever knocked unconscious or had a lapse of memory?	☐ No ☐ Yes	
Have you ever had a lapse of memory?	☐ No ☐ Yes	
Are you presently taking any medications - prescribed or patent?	☐ No ☐ Yes	If yes list below

What medications?

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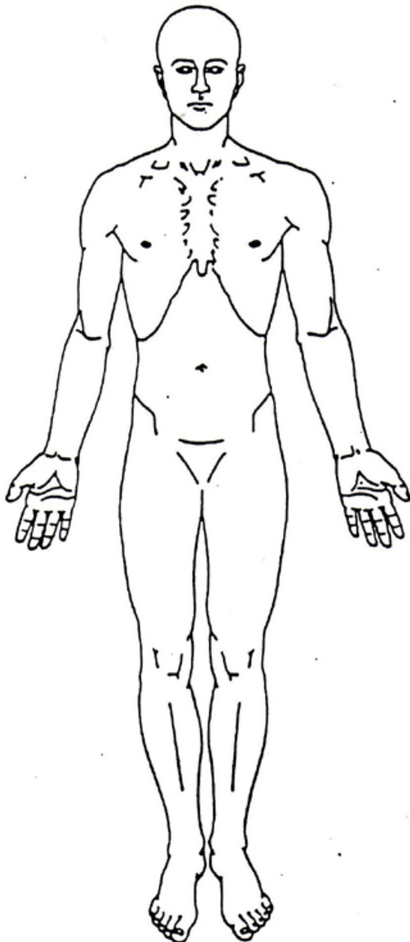
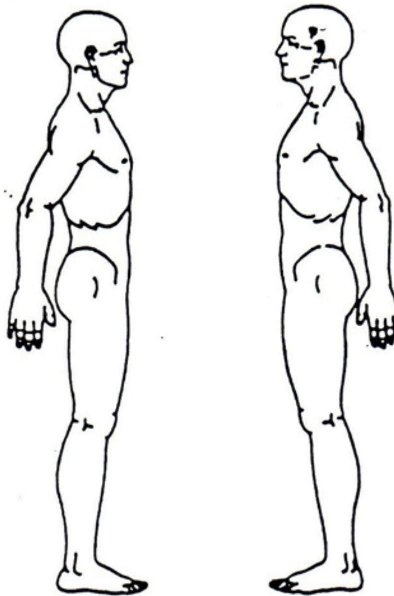
DIAGRAM OF PATIENT’S DISCOMFORT

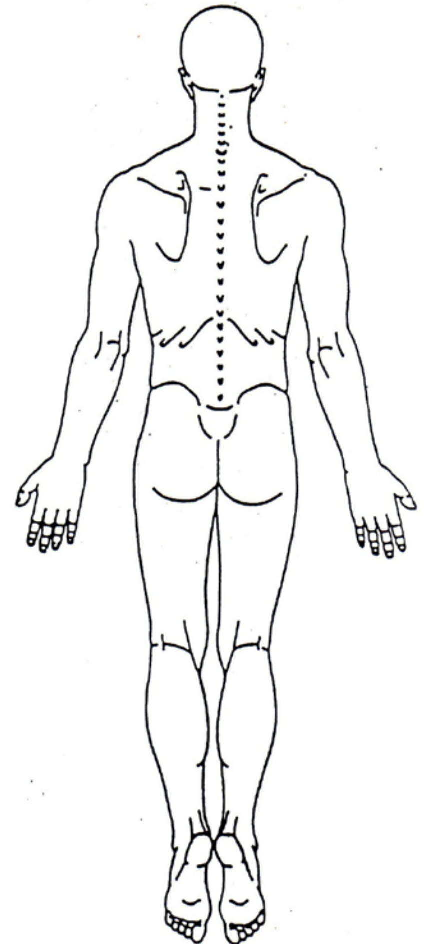
Name		Date
Habits		
☐ Smoke - packs /day	☐ Coffee - Cups/day	☐Alcohol - Amount/day
Exercise		
☐ None ☐ Moderate ☐ Daily	Type of Exercise?	
Do you currently take any vitamins and or supplements?		☐ Yes ☐ No
☐ Over the counter	☐ From my doctor	☐ I send away for them
Please list type you take		

LIST PRESENT COMPLAINTS WITH RATINGS OF 1 - 10 (10 being unbearable Pain)	
1	**1 2 3 4 5 6 7 8 9 10**
2	**1 2 3 4 5 6 7 8 9 10**
3	**1 2 3 4 5 6 7 8 9 10**

Use these figures to mark your pain







Mark with
A for Ache
B for Burning sensations
M for pain with Movement
N for Numbness
P for Pins & needles
S for Sharp/Stabbing pain
T for Tingling sensations
O for Other

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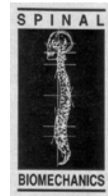


BACK AND NECK PAIN

BACK PAIN			
Currently, I have pain in my	☐ low back	☐ mid back	☐ upper back
My pain began	☐ gradually	☐ suddenly	
I have pain	☐ sometimes	☐ all of the time	
My pain goes into my	☐ right leg	☐ left leg	☐ both
I have tingling and/or numbness In my	☐ right leg	☐ left leg	☐ both

My pain is worse when I:					
cough/sneeze	☐ No	☐ Yes	walk	☐ No	☐ Yes
sit	☐ No	☐ Yes	lift	☐ No	☐ Yes
bend	☐ No	☐ Yes	push	☐ No	☐ Yes
use a computer	☐ No	☐ Yes	pull	☐ No	☐ Yes

My back is worse with sexual activity	☐ No	☐ Yes
My pain wakes me up during the night	☐ No	☐ Yes
Changes in the weather affect my pain	☐ No	☐ Yes

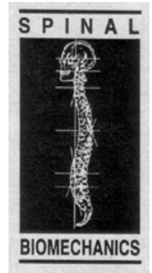
NECK PAIN			
My neck pain began	☐ gradually	☐ suddenly	
I have pain	☐ sometimes	☐ all of the time	
My pain goes into my	☐ right arm	☐ left arm	☐ both
I have tingling and / or numbness in my	☐ right arm	☐ left arm	☐ both

My pain is worse when I:			cough/sneeze	☐ No	☐ Yes
lift	☐ No	☐ Yes	bend forward	☐ No	☐ Yes
push	☐ No	☐ Yes	turn my head	☐ No	☐ Yes
pull	☐ No	☐ Yes	use a computer	☐ No	☐ Yes

My pain wakes me up during the night	☐ No	☐ Yes
Changes In the weather affect my pain	☐ No	☐ Yes
I have neck stiffness	☐ No	☐ Yes
I have headaches	☐ No	☐ Yes
If I do get headaches, they occur	☐ sometimes	☐ all of the time

OTHER PAIN

Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your condition



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HIPAA PATIENT PRIVACY FORM

IN ORDER TO BE COMPLIANT WITH HIPAA REGULATIONS WE REQUEST THAT EACH PATIENT COMPLETE THIS FORM. THIS FORM WILL BECOME A PERMANENT PART OF YOUR MEDICAL RECORDS. THE HIPAA PRIVACY RULES GIVE INDIVIDUALS THE RIGHT TO REQUEST A RESTRICTION ON USES AND DISCLOSURES OF THEIR PROTECTED HEALTH INFORMATION. IN LAYMANS TERMS, WE ARE ASKING FOR YOUR PERMISSION TO SEND ANY PERTANANT HEALTH INFORMATION TO ANOTHER PHYSICIAN, HOSPITAL, LAB, INSURANCE COMPANY OR ANY OTHER ENTITY THAT REQUESTS YOUR INFORMATION FOR REASONS OF CONDUCTING BUSINESS WITH REGARDS TO YOUR CARE. THE TYPES OF INFORMATION THAT ARE TYPICALLY SENT TO ANOTHER ENTITY INCLUDE: MEDICAL RECORDS, LABORATORY OR PATHOLOGY REPORTS, MEDICATIONS LIST, CONSULTATION NOTES, SURGERY NOTES AND PHOTOS AND INSURANCE INFORMATION.

I understand that I have the right to revoke this authorization at any time and that I must put that request in writing and present it to the Privacy Officer at this office I understand that the revocation will not apply to the information that has already been released or to information that is required by law or by my insurance company.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and my treatment will not be altered. I understand that I may view or receive a copy of the information to be used or disclosed.

OUR OFFICE IS COMMITED TO PROTECTING YOUR PRIVACY.
PLEASE LET US KNOW HOW WE CAN CONTACT YOU.

CHECK ALL THAT APPLY

☐ HOME TELEPHONE: ________________________________

☐ YES, YOU ARE PERMITTED TO LEAVE A MESSAGE WITH DETAILED INFORMATION ON MY MACHINE.

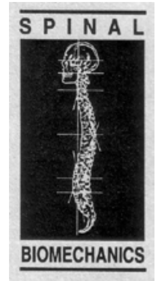
☐ YES, YOU ARE PERMITTED TO LEAVE A MESSAGE WITH ANOTHER ADULT.

OR

☐ N0, DO NOT LEAVE A MESSAGE ON MY MACHINE OR WITH ANOTHER ADULT.

☐ If necessary may we call you at work? If yes, list number____________________________

Signature of patient or legal proxy_________________________________ Date ________/____/__________



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DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC

Name ____

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy and Medicine. Chiropractic health care seeks to restore health through natural means and without the use of medicine or surgery, this given the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Physician's procedures often depends on the environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from Chiropractic health care services.

ANALYSIS

A Chiropractic Physician conducts a clinical analysis for the express purpose of determining whether there is evidence of *Vertebral Subluxation Syndrome (VSS)* or *Vertebral Subluxation Complexes (VSC).* When VSS or VSC complexes are found, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no physician can promise you specific results. This depends on the inherent recuperative powers of the back.

DIAGNOSIS

Although Chiropractic Physicians are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medicine experts. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he has any concern as to the nature of his total condition. Your Chiropractic Physician may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment to other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment or health care if he 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 health care procedures whatever he is suffering from patent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Chiropractic Physician provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC since there are so many variables; it is difficult to predict the time schedule or efficiency of the Chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic, in turn, we must admit that conditions which do not respond chiropractically may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact to provide definite answers to all problems. Both have great strides in alleviating and controlling disease.

The patient should discuss any questions or problems with the doctor before signing this statement of policy.

I HAVE READ THE FOREGOING AND UNDERSTAND IT.

Signature ____ **Date** ______________________

Office Policy – Insurance Assignment

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself.

I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

This office DOES NOT promise that an insurance company will pay, nor does the office promise that an insurance company will or should pay the fees as charged

The office will not enter into a dispute with an insurance company over reimbursements or the amount of reimbursement. This is the patient's obligation.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

The patient also agrees that he/she is responsible for all bills incurred at this office

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.All deductible amounts must be paid prior to insurance submittals

The patient must stay current with their percentage of responsibility (e.g. insurance pays 80% of the bill, and the patient pays 20%). Bills must be paid each visit unless other arrangements have been made.

I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

If the patient discontinues care for any reason other than discharge by the doctor-the bill is due and payable in full-immediately, regardless of any claims submitted.

If patient fails to keep regular appointments they will be discharged. The bill is then due and payable in full-immediately.

If I fail to keep an appointment I maybe charged a no show fee of $10.00 per missed appointment.

It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient at this office.

The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

I hereby authorize the Doctor to examine and treat my conditions he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed.

THERE CAN BE NO EXCEPTIONS TO THE ABOVE WE ARE ONLY TOO HAPPY TO ANSWER QUESTIONS YOU MAY HAVE.

Patient Signature________________________________ Date ____________/_____/________