Neuropathy Consult ROF

blueprint to Neuropathy

Please fill out the application entirely and legibly. We need all information for insurance purposes.

Name _____ **Nickname** _____

Address _____

City _____ **State** _____ **Zip** _____

Phone _____ **Email** _____

We will need to contact you both by phone & email. Please be sure to give us the best phone number to reach you

Date of Birth _____ **Social Security** _____

If you have Medicare, we need you to list your SSN above or provide us with the Medicare card

Spouse's Name _____ **Phone Number** _____

Your Occupation _____ **Retired?** Yes ☐ No ☐

REVIEW OF SYMPTOMS

Please check all that apply

☐ Foot Pain	☐ Diabetes	☐ Spinal Stenosis	☐ Cancer	☐ Pinched Nerve
☐ Hand Pain	☐ High Cholesterol	☐ Degenerative Disc	☐ Chemotherapy	☐ Poor Circulation
☐ Low Back Pain	☐ High Blood Pressure	☐ Vascular Problems	☐ Arthritis in Hands	☐ Joint Replacement
☐ Neck Pain	☐ Pacemaker/ Defibrillator	☐ Leg Pain	☐ Arthritis in Feet	☐ Foot Surgery
☐ Foot Numbness	☐ Herniated Disc	☐ Plantar Fasciitis	☐ Implanted Cord/ Bladder Stimulator	☐ Poor wound healing
☐ Hand Numbness	☐ Bulging Disc	☐ Morton's Neuroma	☐ Sciatica	☐ Excessive thirst or urination

PRESENT HEALTH CONDITION

In order of importance, list the health problems you are most interested in getting corrected:

1. _____
2. _____
3. _____
4. _____

List approximately how long you have noticed these problems:

1. _____
2. _____
3. _____
4. _____

Is there a certain time of day any of these problems are better or worse?

_____

_____

_____

_____

List the things you have used for these problems:

Gabapentin Neurontin Lyrica Cymbalta Physical Therapy Pain Medications Aleve Tylenol Ibuprofen Motrin Chiropractic Massage Therapy Injections Creams

Is your balance/walking ability affected?
If yes, please describe:

_____

_____

_____

_____

What do you think is causing your problem?

_____

_____

_____

_____

Name of all doctors you have seen for these problems and treatment you received:

_____

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Have your symptoms: ☐ Improved ☐ Worsened ☐ Stayed the same

List anything that makes your condition worse _____

_____

List anything that makes your condition better _____

_____

How would you describe the symptoms? Please check ALL that apply

☐ Aching Pain	☐ Numbness	☐ Hot Sensation	☐ Cramping
☐ Stabbing Pain	☐ Tingling	☐ Throbbing Pain	☐ Swelling
☐ Sharp Pain	☐ Pins & Needles Pain	☐ Dead Feeling	☐ Burning
☐ Tiredness	☐ Heavy Feeling	☐ Cold Hands/Feet	☐ Electric Shocks

Is this condition interfering with any of the following?

☐ Sleep	☐ Work	☐ Daily Activities
☐ Recreational Activities	☐ Walking	☐ Standing

SOCIAL HISTORY

Do you smoke? Yes ☐ No ☐ If yes, how many cigarettes daily? _____

Do you drink? Yes ☐ No ☐ If yes, how many drinks per week? _____

Do you exercise regularly? Yes ☐ No ☐ If yes, please describe type & how often: _____

_____

_____

CURRENT PAIN LEVELS

How would you rate your pain in the last week?

NO PAIN **1 2 3 4 5 6 7 8 9 10** WORST PAIN POSSIBLE

If you had to accept some level of pain after completion of treatment, what would be an acceptable level?

NO PAIN **1 2 3 4 5 6 7 8 9 10** WORST PAIN POSSIBLE

PREVIOUS HEALTH HISTORYHEALTH

This is a confidential record of your medical history and pertinent personal information. The doctor reserves the right to discuss this information with medical and allied health professionals per the informed consent. Copies of this record can only be released by your written authorization, unless you sign here indicating that we can release copies by your verbal request.

Name _____ ***Signature*** _____

Please give name, address, and office phone number of your primary care physician.

Name _____ ***Phone*** _____ ***Address*** _____

When were you last seen there?

_____

May we send them updates on your treatment/condition? Yes ☐ No ☐

List ALL allergies/sensitivities to medication, food, and other items here:

Item you react to:	*Reaction:*

List the prescription drugs you are currently taking (or you may attach a list):

Name	*Dose (mg or IU)*	*Times Daily*

List all nutritional supplements (vitamins, herbs, homeopathics, etc.) as above:

Patient Quality Of Life Survey Example

blueprint to Neuropathy

PRACTICE INFORMATION HERE

Patient Quality Of Life Survey

Name: _____ ***Date:*** _____

Please take several minutes to answer these questions so we can help you get better.
(Please circle as many that apply)

1. How have you taken care of your health in the past?
   - **a.** Medications
   - **b.** Emergency Room
   - **c.** Routine Medical
   - **d.** Exercise
   - **e.** Nutrition/Diet
   - **f.** Holistic Care
   - **g.** Vitamins
   - **h.** Chiropractic
   - **i.** Other (please specify): _____

2. How did the previous method(s) work out for you?
   - **a.** Bad results
   - **b.** Some results
   - **c.** Great results
   - **d.** Nothing changed
   - **e.** Did not get worse
   - **f.** Did not work very long
   - **g.** Still trying
   - **h.** Confused

3. How have others been affected by your health condition?
   - **a.** No one is affected
   - **b.** Haven't noticed any problem
   - **c.** They tell me to do something
   - **d.** People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?
   - **a.** Job
   - **b.** Kids
   - **c.** Future ability
   - **d.** Marriage
   - **e.** Self-esteem
   - **f.** Sleep
   - **g.** Time
   - **h.** Finances
   - **i.** Freedom

5 Are there health conditions you are afraid this might turn into?

a. Family health problems
b. Heart disease
c. Cancer
d. Diabetes
e. Arthritis
f. Fibromyalgia
g. Depression
h. Chronic Fatigue
i. Need surgery

How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:

What are you most concerned with regarding your problem?

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific

What would be different/better without this problem? Please be specific

What do you desire most to get from working with us?

What would that mean to you?

DYNAMIC SPINE
Chiropractic Health Center

Acknowledgements

*Initials_____ I have read and reviewed the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

*Initials_____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):_____

*Initials_____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in the office.

*Initials_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

*Initials_____ I may request a copy of the Financial Policy at any time.

*Initials_____ I authorize my insurance company or administrator to pay Dynamic Spine Chiropractic Health Center P.C. directly for the benefits otherwise payable to me under my current policy.

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature:_____

DATE:_____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights or privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is disclosed to carry out treatment, payment, or healthcare operation.

I have reviewed the Notice of Privacy Practices and I have been provided an opportunity to review it.

SIGNATURE:_____

DATE:_____

If the patient is a minor child, please print the child's full name:_____

Witness_____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

*Patient Name:_____ * Signature:_____ *Date:_____

*Parent or Guardian:_____*Signature:_____ * Date:_____

Witness Name:_____ Signature:_____ Date:_____

Doctor’s Signature: _____

Date Completed: _____

Terms of Acceptance - Billing Policy

I acknowledge that I understand and agree that Dynamic Spine Chiropractic Health Center is a Non-participating provider with _____.

I am covered by the above health insurance plan(s). However, the health plan in-under which I am covered may or may not include benefits for some or all of the services provided by Dynamic Spine Chiropractic Health Center. Despite the above, I understand that Dynamic Spine Chiropractic Health Center will not be submitting any claims to my insurance for the services provided to me by Dynamic Spine Chiropractic Health Center.

Until such time as I may otherwise advise Dynamic Spine Chiropractic Health Center in writing, I elect to pay for all services I receive from Dynamic Spine Chiropractic Health Center at Dynamic Spine Chiropractic Health Center rates. I have fully read this Election to Self-Pay for services form and have had the opportunity to ask any questions that I may have had about this form and any questions that I may have had about this form have been answered to my satisfaction. I have agreed and freely chosen to self-pay for my services provided by Dynamic Spine Chiropractic Health Center after having asked Dynamic Spine Chiropractic Health Center about payment options and having carefully considered those options.

I also acknowledge and understand that I am being given the opportunity by Dynamic Spine Chiropractic Health Center to submit my own insurance claims at my own leisure.

X_____ Date:_____

(patient signature or responsible party if patient is a minor or is otherwise unable to sign for him herself)

X_____ _____

(printed name of patient or responsible party) capacity of the responsible party (e.g. parent, guardian, etc.)

ITEMIZED RECEIPTS, aka. “SUPERBILLS”

Our fees and charges are based on the cost of doing business and providing patients with the highest quality of care possible. Patients are responsible for payment of any services provided. You will be given a receipt with a description of services received, more commonly referred to as a “superbill”, along with the related charges that you, in turn, can submit to your own insurance company for possible reimbursement, as well as retain for your personal records.

HMO’s and PPO’s limit their covered services to those they deem ‘medically necessary’ and are performed by a doctor that is employed by the insurance company or “in network” in the plan. This office does not participate with any insurance provider or accept such an assignment other than with Part B Medicare. We always make recommendations based on what you need, not based on an insurance company’s limited coverage. It is our policy to discuss fees before services are provided, so please feel free to discuss fees or charges with the doctor or our staff.

Please let us know, by checking an option below, which you request:

- □ **YES, I would like Superbills.**
- □ **NO, I do not need Superbills.**

By signing below, I verify that, I clearly understand that all insurance coverage, whether accident, auto, work related, or general coverage is an arrangement between my insurance carrier and myself.. This office may provide any necessary reports subject to reasonable service fees to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. This office may provide any necessary medical records if requested. These reports may be subject to reasonable service fees. Medical records are provided with proper authorization, and fees charged are according to our HIPAA policies.

Patient’s Signature_____ Date ____/____/____