Dr. Eric M. Young · Dr. Robert J. Graham

PUEBLO
Chiropractic Center

Chiropractic Registration and History

Patient Information

Patient Name: _____

DOB: _____ Gender: Male Female

Address: _____

City:_____ State:_____ Zip:_____

Phone Number:_____ Secondary:_____

Social Security Number:_____

Marital status:

Married Widowed Divorced Single

Occupation: _____

Employer or school: _____

Emergency Contact:

Name:_____

Number: _____Relationship: _____

Whom may we thank for referring you?

_____

_____

I certify that all the above information is correct:

Sign:_____ Date:_____

Insurance Information

PRIMARY

Insurance Company:_____

Subscriber name: _____

ID #: _____ Group#: _____

SECONDARY

Insurance Company: _____

Subscriber Name: _____

ID#: _____ Group#:_____

Assignment and release:

I certify that I, and/or my dependent(s) have ins. coverage with _____ and assign directly to Drs Young and Graham all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid or not by my insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for these services and determining insurance benefits payable for related services.

Sign:_____ Date:_____

Patient Condition

Reason for visit: _____

_____

Is this condition due to an accident? Yes No Date:_____ Type: Work Auto Other

To whom have you made a report of your accident: Employer Worker Comp. Other

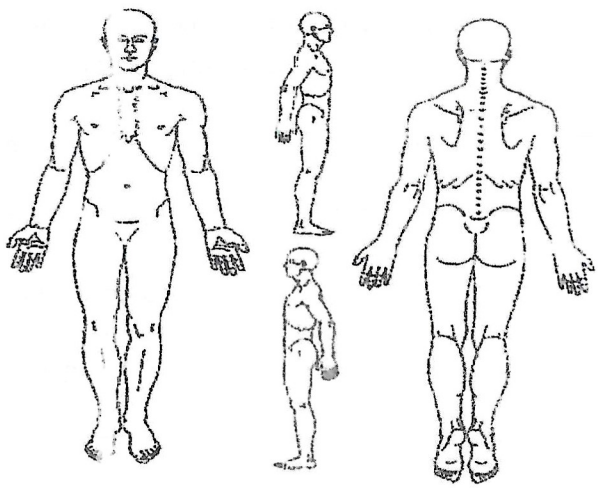
Attorney name: _____ Law Firm: _____

When did symptoms start: _____ Has it become progressively worse? Yes No

Mark the picture where you have pain.

XXXXXXX ********* ////////// >>>>>>>>> ~~~~~~~~

Aching Numbness Tingling Stabbing Pins & needles



Rate the severity of your pain on a scale of 1-10: _____
(1 being the least, 10 being the worst)

Type of pain: Sharp Burning Throbbing Numbness

Aching Shooting Burning Tingling

Cramps Stiffness Swelling

Other: _____

How often do you have this pain? _____

Is the pain constant or come and go? _____

Does the pain interfere with: Work Sleep Daily Routine Recreation

Activities that are painful to preform? Sitting Standing Walking Bending Laying Down

By signing below I certify that all information I have provided is correct. I understand that providing incorrect information could be detrimental to my health.

Sign: _____ Date:_____

Print: _____

Health History

Patient Name: _____ DOB: _____

What treatment have you received for your condition? Medication Surgery Physical Therapy Chiropractic None Other:_____

Name of doctor(s) who have treated you for this condition: _____

Date of last:

Physical Exam:_____ Spinal X-ray: _____ Blood test: _____

Spinal Exam: _____ Chest X-ray: _____ Urine Test: _____

Dental X-ray: _____ MRI, CT Scan, Bone Scan: _____

Please circle yes or no to indicate if you have any of the following:

AIDS/HIV	yes	no	Liver Disease	yes	no
Alcoholism	yes	no	Measles	yes	no
Allergy Shots	yes	no	Migriane Headaches	yes	no
Anemia	yes	no	Miscarriage	yes	no
Anorexia	yes	no	Mononucleosis	yes	no
Appendicitis	yes	no	Multiple Sclerosis	yes	no
Arthritis	yes	no	Mumps	yes	no
Asthma	yes	no	Osteoporosis	yes	no
Bleeding Disorder	yes	no	Pacemaker	yes	no
Breast Lump	yes	no	Parkinson's Disease	yes	no
Bronchitis	yes	no	Pinched Nerve	yes	no
Bullimia	yes	no	Pneumonia	yes	no
Cancer	yes	no	Polio	yes	no
Cataracts	yes	no	Prostate problem	yes	no
Chemical Dependency	yes	no	Prosthesis	yes	no
Chicken Pox	yes	no	Psychiatric care	yes	no
Diabetes	yes	no	Rheumatoid Arthritis	yes	no
Emphysema	yes	no	Rheumatic Fever	yes	no
Epilepsy	yes	no	Scarlet Fever	yes	no
Fractures	yes	no	STD	yes	no
Glaucoma	yes	no	Stroke	yes	no
Goiter	yes	no	Suicide Attempt	yes	no
Gonorrhea	yes	no	Thyroid Problem	yes	no
Gout	yes	no	Tonsilitis	yes	no
Heart Disease	yes	no	TB	yes	no
Hepatitis	yes	no	Tumors/Growths	yes	no
Hernia	yes	no	Typhoid Fever	yes	no
Herniated Disk	yes	no	Vaginal Infections	yes	no
Herpes	yes	no	Whooping Cough	yes	no
High Blood Pressure	yes	no	Other: _____		
High Cholesterol	yes	no	_____		
Kidney Disease	yes	no			

Health History Continued

Patient Name:_____ DOB: _____

Exercize	Work Activity	Habits	
None	Sitting	Smoking	Packs/Day: _____
Moderate	Standing	alcohol	Drinks/Week:_____
Daily	Light Labor	coffee/caffiene	Cups/Day:_____
Heavy	Heavy Labor	High stress level	Reason:_____

Are you Pregnant? Yes No Due Date: _____

Injuries/surgeries you have had	Description	Date
Falls	_____	_____
Head injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

By signing below I certify that all information I have provided is correct. I understand that providing incorrect information could be detrimental to my health.

Sign: _____ Date:_____

Print: _____

Medical Records Release: HIPAA Authorization to Use or Disclose Health Information

Patient Name: _____ DOB: _____

Address: _____ Telephone: _____

I authorize the use or disclosure of the above named individual's health information as described below.
The following individual(s) or organization(s) are authorized to make disclosure: _____

_____

The type of information to be used or disclosed is as follows (check the appropriate boxes)

- Entire medical record
- Lab results
- Xray and imaging reports
- Consultation reports
- Other (Please describe): _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), of human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

The information identified above may be used or disclosed to the following individuals or organization(s):

Pueblo Chiropractic Center
1515 Fortino Blvd Ste 140
Pueblo, CO 81008
P: 719-542-1399
F: 719-583-2024

This information for which I authorize disclosure will be used for the following purpose:
CONTINUED TREATMENT

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the privacy officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and federal privacy laws or regulations may not protect the information. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Signature of patient or legal Representitive: _____ Date: _____

Printed Name: _____ Relationship to patient: _____

Pueblo Chiropractic Center

Welcome to our practice!

Please be advised we will submit all charges to your insurance, however it is your responcibility to provide our office with updated insurance information. This includes auto insurances (if applicable).

Financial Policy

*Should your insurance require a referral, it is your responsibility to obtain this prior to your exam

*You are required to pay, in full, for each visit at the time of service. Your co-pay is required each visit. Non-payment of co-pays is monitored by insurance companies and could result in termination of your coverage.

*Co-Insurance balances are due within 30 days of EOB receipt. Please monitor your insurance explanation of benefits for clarification.

*You are required to inform Pueblo Chiropractic Center of any change in name or address

* If you are being treated for a work related or auto related injury, it is your responsibility to provide our office with any and all information necessary to receive payment or it could be your responsibility to pay.

*If you fail to pay on your account when due or fail to comply with any other term in this financial policy the balance on the account will be considered in default.

* Should Pueblo Chiropractic Center prevail in a lawsuit to collect in this debt , Pueblo Chiropractic Center will include all court costs, collection agency costs, and attorney's fees in an amount that the court finds reasonable.

I agree to the above and agree to be personally responsible for full payment of my account

Patient Name: _____ Date: _____

Signature: _____ Relationship: _____

HIPAA Act ACS X12

** Rule 5010 for Health Care Providers effective 01/01/12: The Dept. of Health & Human Services rule 45 CFR Part 162 of the Health Insurance Reform; Hippa Act, ACS X12 standards, requires all health care providers to report race ethnicity and language spoken. **

Race: Asian Black Caucasian Other Declined

Ethnicity: Hispanic Non- Hispanic Declined Language Spoken: _____

Privacy Policy

Privacy Practice Notice:

I have read the notice of Privacy Practices and do understand my rights. I understand that my doctor and their staff shall preserve the integrity and confidentiality of protected health information.

Copy requested: _____ No Copy Requested: _____

Constent to Treat

I give consent to be treated myself or for the individual to whom I am responsible for.

Signature of patient or guardian: _____ Date: _____

NECK DISABILITY INDEX

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU. ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT -DAY SITUATION.

SECTION 1 - PAIN INTENSITY

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally, but it causes extra pain.
- ☐ It is painful to look after myself, and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self -care.
- ☐ I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 – LIFTING

- ☐ I can lift heavy weights without causing extra pain.
- ☐ I can lift heavy weights, but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 – WORK

- ☐ I can do as much work as I want.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I can't do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

SECTION 5 – HEADACHES

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

SECTION 6 – CONCENTRATION

- ☐ I can concentrate fully without difficulty.
- ☐ I can concentrate fully with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating.
- ☐ I have a lot of difficulty concentrating.
- ☐ I have a great deal of difficulty concentrating.
- ☐ I can't concentrate at all.

SECTION 7 – SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed for less than 1 hour.
- ☐ My sleep is mildly disturbed for up to 1-2 hours.
- ☐ My sleep is moderately disturbed for up to 2-3 hours.
- ☐ My sleep is greatly disturbed for up to 3-5 hours.
- ☐ My sleep is completely disturbed for up to 5-7 hours.

SECTION 8 – DRIVING

- ☐ I can drive my car without neck pain.
- ☐ I can drive as long as I want with slight neck pain.
- ☐ I can drive as long as I want with moderate neck pain.
- ☐ I can't drive as long as I want because of moderate neck pain.
- ☐ I can hardly drive at all because of severe neck pain.
- ☐ I can't drive my care at all because of neck pain.

SECTION 9 – READING

- ☐ I can read as much as I want with no neck pain.
- ☐ I can read as much as I want with slight neck pain.
- ☐ I can read as much as I want with moderate neck pain.
- ☐ I can't read as much as I want because of moderate neck pain.
- ☐ I can't read as much as I want because of severe neck pain.
- ☐ I can't read at all.

SECTION 10 – RECREATION

- ☐ I have no neck pain during all recreational activities.
- ☐ I have some neck pain with all recreational activities.
- ☐ I have some neck pain with a few recreational activities.
- ☐ I have neck pain with most recreational activities.
- ☐ I can hardly do recreational activities due to neck pain.
- ☐ I can't do any recreational activities due to neck pain.

PATIENT NAME _____ DATE _____

SCORE _____ [50] BENCHMARK -5 = _____

Oswestry Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

No pain 0 1 2 3 4 5 6 7 8 9 10 *Unbearable pain*

Name _____ **Date** _____

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1 – Pain Intensity
0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)
0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4 – Walking
0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 – Sitting
0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 – Standing
0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with tim
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing p
5. I avoid standing because it increases the pain immediately.

Section 7 – Sleeping
0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less tha one-quarter.
3. Because of pain my normal nights sleep is reduced by less tha one-half.
4. Because of pain my normal nights sleep is reduced by less tha three-quarters.
5. Pain prevents me from sleeping at all.

Section 8 – Social Life
0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limitir my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Section 9 – Traveling
0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to se alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternati forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

TOTAL _____

Fairbank, J.C., Couper, J., Davies, J.B., & O'Brien, J.P. (1980). The Oswestry low back pain disability questionnaire. Physiotherapy, 66, 271-273.

*(A)*Notifier(s):Pueblo Chiropractic Center

(B) Patient Name: *(C)* Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for *(D* Initial Evaluation 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)*** **Inital Eval** below.

(D)	*(E)* Reason Medicare May Not Pay:	*(F)* Estimated Cost:
Initial Evaluation	Not Covered	$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)*** **Initial Eval** 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)*** **Initial Eval** 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)*** **Initial Eval** 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)*** **Initial Eval** 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: