Chiropractic Family Health Center

Dr Kimberly J Bailey/Dr Isaiah R Stephan

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ___-___-____ Work Phone: ___-___-____ Cell Phone: ___-___-____

Email Address: _____ Do you want our monthly newsletter? _____

Occupation: _____ Place of employment: _____

Date of Birth: _____ Age: _____ Social Security #: ___-___-____ Gender: Male - Female

Name of spouse: _____ Preferred language: _____ Race/Ethinicity: _____

Who is your primary care physician? _____

Who may we thank for referring you to our office? _____ Relationship: _____

Name of health insurance: _____ Who is primary holder: _____ Through where: _____

Did you check your chiropractic coverage? _____ What do you believe your coverage is? _____

List any Allergies:

☐ Amoxil ☐ Animals ☐ Aspirin ☐ Bees ☐ Chocolate ☐ Codeine ☐ Dairy ☐ Dust ☐ Eggs ☐ Environmental

☐ Latex ☐ Molds ☐ Nickel ☐ NONE ☐ Peanut/Tree Nuts ☐ Penicillin ☐ Ragweed/Pollen

☐ Rubber ☐ Seasonal Allergies ☐ Shellfish ☐ Soaps ☐ Sulfa ☐ Wheat ☐ X-Ray Dye ☐ Other: _____

Check any Surgeries that you have had:

☐ Appendix ☐ Back ☐ Brain ☐ Carpal Tunnel ☐ Cervical Disk ☐ Chest ☐ Disc ☐ EENT ☐ Elbow ☐ Foot

☐ Gallbladder ☐ Gastrointestinal ☐ Gynecological ☐ Heart ☐ Hernia ☐ Hip ☐ Knee ☐ Lumbar Disc ☐ Neck

☐ Neurological ☐ Obstetrical ☐ Podiatric ☐ Shoulder ☐ Thoracic Disc ☐ Wrist ☐ Other: _____

List ALL PAST Medical History conditions:

☐ Acid Reflux ☐ Anxiety ☐ Ankle Pain ☐ Arm Pain ☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Broken Bones

☐ Cancer ☐ Carpal Tunnel ☐ Chest Pain ☐ Constipation ☐ COPD ☐ Crohn's Disease ☐ Depression

☐ Diabetes ☐ Dizziness ☐ Ear Infections ☐ Elbow Pain ☐ Epilepsy ☐ Eye/Vision Problems ☐ Fainting

☐ Fatigue ☐ Fibromyalgia ☐ Foot Pain ☐ Genetic Spinal Condition ☐ GERD ☐ Gout ☐ Hand Pain

☐ Headaches ☐ Hearing Problems ☐ Hepatitis ☐ High Blood Pressure ☐ High Cholesterol ☐ Hip Pain ☐ HIV

☐ Jaw Pain ☐ Joint Stiffness ☐ Knee Pain ☐ Leg Pain ☐ Low back pain ☐ Lupus ☐ Menstrual Problems

☐ Mid-Back Pain ☐ Minor Heart Problem ☐ Multiple Sclerosis ☐ Neck Pain ☐ Neurological Problems

☐ Osteopenia ☐ Osteoporosis ☐ Pacemaker ☐ Parkinson's ☐ Polio ☐ Prostate ☐ Rib Pain ☐ Scoliosis

☐ Shoulder Pain ☐ Significant Weight Change ☐ Sleep Apnea ☐ Spinal Cord Injury ☐ Sprain/Strain

☐ Stroke/Heart Attack ☐ Other: _____

What is your major complaint?

*****(please list** **only one**** on this page and do your next complaint on the next page):

Circle: neck -mid back -Low back —— other: _____

Side: ☐ left ☐ right ☐ center ☐ both **Date problem began:** _____

How did this problem begin (falling, lifting, etc.)? _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain) :

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Intensity: ☐mild ☐moderate ☐severe ☐unbearable ☐none

Describe the nature of your symptoms:

☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Tightness

☐ Stabbing ☐ Throbbing ☐ Radiating Pain-radiates to _____

What makes your pain better?

☐Acupuncture☐Chiropractic☐Heat☐Ice☐Massage☐Nothing☐PainMeds☐Sleep/rest☐Stretching

What are your expectations?:

☐Become pain free ☐Explanation of my condition ☐Learn how to care for condition on my own ☐Reduce sympton

☐Resume normal activity

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

What activities aggravate your condition:

- o Bathing
- o Bending
- o Bending Arm
- o Bending Leg
- o Care of others/Pets
- o Caring for Children
- o Carrying Objects
- o Climbing Stairs
- o Concentrating
- o Cooking/Cleaning
- o Crouching/Squatting
- o Doing Hobbies
- o Dressing
- o Driving
- o Exercise/Sports
- o Gardening
- o General Mobility
- o Holding onto objects
- o Keeping balance
- o Knitting
- o Leaning
- o Lifting
- o Lying down
- o Moving Joint/s
- o Mowing
- o Personal hygiene/Grooming
- o Reaching out/up/down
- o Seeing
- o Sewing
- o Sexual Activity
- o Shopping
- o Sitting
- o Sleeping
- o Standing
- o Turning
- o Twisting
- o Using the phone
- o Walking
- o Working
- o Yard work

This form was reviewed by: _____

What is your 2nd complaint? _____

Circle: neck -mid back -Low back —— other: _____

Side: ☐ left ☐ right ☐ center ☐ both **Date problem began:** _____

How did this problem begin (falling, lifting, etc.)? _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain) :

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

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This form was reviewed by: _____

Have you ever had chiropractic care at another office?_____When?_____ Where?_____

If so, did you have xrays?_____When was your last adjustment?_____

Date of last x-ray:_____

****Please list your Medications/supplements and what they are for (OR GIVE US A LIST ON A SEPARATE PIECE OF PAPER**

_____

_____

_____

Please list MEDICATIONS that you are allergic to:_____

List your **Family History:**

Example: Maternal Grandmother – High blood pressure or Paternal Grandfather – Heart disease etc

_____

_____

_____

_____

Do you smoke? ☐ No ☐Yes

Do you drink alcohol? ☐ No ☐Yes - how many per day? _____

Do you drink caffeine? ☐ No ☐Yes - how many per day? _____

Do you exercise? ☐ No ☐Yes (what forms and how often):

_____

What is your favorite sleeping position? _____

Are you now pregnant?____Are you wearing any form or arch supports or orthotics?_____

What kind of mattress do you now sleep on? _____How old is your mattress? _____

In case of emergency or someone who may know how to reach you in case we cannot find you to reschedule, please call

_____

Name – relationship-telephone number

_____

Name – relationship-telephone number

Chiropractic Family Health Center
Dr. Bailey and Dr. Stephan

Patient Name: _____ **Date of Birth:** _____/_____/_____

Physical Activity Readiness Questionnaire (PAR-Q)

1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
   ☐ Yes ☐ No If yes, please explain: _____

   _____

2. Do you feel pain in your chest when you do physical activity?
   ☐ Yes ☐ No If yes, please explain: _____

   _____

3. In the past month, have you had chest pain when you were not doing physical activity?
   ☐ Yes ☐ No If yes, please explain: _____

   _____

4. Do you lose your balance because of dizziness or do you ever lose consciousness?
   ☐ Yes ☐ No If yes, please explain: _____

   _____

5. Do you have a bone, your joint problem that could be made worse by a change in your physical activity?
   ☐ Yes ☐ No If yes, please explain: _____

   _____

6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
   ☐ Yes ☐ No If yes, please explain: _____

   _____

7. Do you know of any other reason why you should not do physical activity?
   ☐ Yes ☐ No If yes, please explain: _____

   _____

CHIROPRACTIC FAMILY HEALTH CENTER

138 Halifax Street
Winslow, ME. 04901

Dr. Kimberly Bailey Shaw
Dr. Isaiah Stephan
Dr. Christina Lavertu Steenstra

Tel: (207)873-5161
Fax: (207)873-5163

Authorization to Release of Confidential Healthcare Information

Patient Name: _____

Date of Birth_____ **Telephone:**_____ **SSN:**_____

I authorize release of my medical records from:

Physician/Facility:_____ Telephone#:_____ Fax#:_____

Address:_____ City:_____ State:_____ Zip:_____

RELEASE TO: **Chiropractic Family Health Center-**
Fax to: 207-873-5163 or **mail** to: PO Box 8120 Winslow, Maine 04901

Please release the following (check all that apply):

( ) Office notes/treatment ( ) X-ray and/or Lab ( ) MRI/CT reports
( ) History & Physical ( ) Emergency Room ( ) Psychosocial evaluation
( ) Operative Report ( ) Pathology Report ( ) Psychiatric/Psychological evaluation
( ) Current conditions ( ) Current medications list including allergies to medication
( ) Other_____

I release the above information for the purpose or purposes of:

( ) Ongoing treatment/aftercare ( ) At the request of the individual

I understand that:

- Signing this authorization is not a condition to treatment, payment, enrollment and eligibility for benefits.
- I can refuse to disclose some or all of the information in my treatment records, but if I do so, it could result in an improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other adverse consequences.
- I can revoke all or part of this authorization, in writing, at any time by delivering a written, dated, and signed notification to the facility indicated above except to the extent that the Chiropractic Family Health Center has already acted in reliance on it.
- I am entitled to a copy of this authorization upon request.
- I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization.

* _____

Signature of patient, guardian, conservator or patient representative (please circle if not patient) Date

This consent is valid for 90 days. It may be revoked by the signer at any time.

*Use of this information for any other than the stated purpose is prohibited
*This information is for the use of the designated recipient only and cannot be provided to any other agency

INFORMED CONSENT

Chiropractic doctors who perform manipulation are required by law to obtain your informed consent before starting treatment.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I understand that in very isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Strokes from chiropractic adjustments are very rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning.

Tests will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Reasonable alternatives to these procedures have been explained to me. I understand that neglecting care may have potential risks that may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation and worsening pathology, as well as a lowered immune system leading to disease.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction. I have made my decision voluntarily and freely.

Chiropractic Family Health Center
Dr. Kimberly J. Bailey/Dr. Isaiah R. Stephan
PO Box 8120 138 Halifax Street
Winslow, Maine 04901

Patient's Written Acknowledgement of Doctor's Notice of Privacy Practices

I, _____, acknowledge that I have been given the opportunity to read the *Chiropractic Family Health Center's,* Notice of Privacy Practices located in the reception area.

Signature:_____ Date:_____

Consent to Care

I,_____, permit Dr. Kimberly J Bailey and whomever she designates as her associate to administer chiropractic care as she deems necessary. Chiropractic benefits may be covered by my insurance, but I know that I am personally responsible for payment of services rendered. I have received information about risks and benefits involved in the evaluation of my condition and recommended treatments.

Signature:_____ Date:_____

CONSENT TO X-RAY (PARENT AUTHORIZING XRAYS ON A MINOR CHILD)

I, _____authorize Dr. Kimberly Bailey or her associate to take any x-rays necessary for diagnosis and treatment of _____(minor's name).

Signature:_____ Date:_____

PAYMENT AND/OR ASSIGNMENT OF BENEFITS

I UNDERSTAND I AM RESPONSIBLE FOR PAYING ALL COSTS ASSOCIATED WITH MY EVALUATION AND CARE. If I have health insurance, I understand I am financially responsible in the event all or some payment is denied by my insurance carrier. **I am also responsible for those charges not covered by my insurance as deductible, co-pays and any other treatment that are not included as an insurance benefit.**

I authorize my health insurance carrier(s) or third parties that are responsible for paying for my health care to pay costs associated with my evaluation and care directly to the Chiropractic Family Health Center. **This is a direct assignment of my rights and benefits under this policy.** A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the Chiropractic Family Health Center to appeal any unfavorable payment decisions on my behalf. I further authorize the release of any information pertinent to the appeal to the insurance company involved in this case. I authorize the Chiropractic Family Health Center to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature:_____ **Date:**_____

Insurance

We currently participate with Anthem Blue Cross/Blue Shield, Mednet, Harvard Pilgrim, Aetna, Cigna, Maine Employer's Mutual, PHCS, Prism, United Healthcare, CompNet, and Medicare. If we accept your insurance, we will bill your insurance company directly and have you assign payment to us. You are required to complete and sign our Insurance Questionnaire below and return it to this office on your second visit. **Those requiring referrals from a primary doctor must obtain them as needed.**

You are responsible to pay any and all uncovered portions of the bill at the time of service. Most insurance companies do not cover supports, orthopedic pillows, or nutritional supplements. You will be charged for these, in full, upon receipt. Should the insurance company consider any of these; your account will be credited.

If your insurance company does not pay the full benefit within 60 days, we ask that you contact the insurance to help speed things up. We will also make additional attempts in collecting from the insurance company. If the insurance does not pay within 90 days, we will transfer the balance to you. You may attempt to collect reimbursement from them at this point. Should your insurance company pay more than expected, you will be credited. The insurance company may or may not request reimbursement of any such overpayments; this will be your responsibility.

Insurance Questionnaire

Patient's name:_____ ID #:_____

Insured's name:_____ Employer:_____

Address:_____ Address:_____

Home Phone #:_____ Work Phone #:_____

Date of Birth:_____ Sex: M F

Name of representative spoken with:_____ Date called:_____

Insurance Company:_____ Effective date:_____ What is my group number_____

Is there a pre-existing clause?_____ If yes, explain:_____

Does this policy cover Chiropractic Care?_____ Percentage of coverage:_____

Is there a deductible?_____ If yes, how much?_____ Has it been met?_____

Deductible start date:_____ Is there a 3 month end of year carryover?_____

What is the office visit / exam co-pay?_____ Date of service co-pay?_____

Is there a visit maximum?_____ If yes, explain:_____

Is there a yearly maximum?_____ If yes, explain:_____

Is precertification or referral required?_____ If yes, is there one on file?_____

Modalities 97014 & 97035:_____

X-rays:_____

Therapeutic Exercise 97110:_____

FINANCIAL POLICY

Thank you for choosing us as your health care provider. Our main concern is that you receive proper treatments needed to restore your health. Therefore, if you have any questions or concerns about our policy, please do not hesitate to ask our Accounts Manager.

All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Our relationship is with you, not your insurance company. Returned checks, balances over 30 days, and **missed appointments** are subject to additional fees. All services must be paid at the time of service. For accounts previously in collections, services must be prepaid.

Private Pay

We accept cash, checks, Mastercard, and Visa. Credit plans for long term treatment must be pre-approved by our Accounts Manager. The adult accompanying a minor, and his/her parents (or guardians), are responsible for payment at the time of service. The parents (or guardians) are responsible for payment of unaccompanied minors at the time of service. Non-emergency treatment will be denied unless payment is received or charges have been pre-authorized to Mastercard or Visa.

Medicare

The doctors accept assignment on Medicare claims for spinal manipulations. You are required to pay for all services that are not covered by Medicare at the time of service (for example: exams, x-rays taken in this office, therapies, exercises, supplements, and supports). In the case that a secondary insurance is involved, proper arrangements will be made with the Accounts Manager.

Worker's Compensation

You are required to supply this office with a copy of the First Report of Injury filed with your employer. You also need to complete our Accident Report. We will complete a Practitioner M-1 Report. In the event that your claim is denied, we will bill your personal health insurance. You must keep this office informed of any changes. Bring in any and all paperwork sent to you regarding your claim as soon as possible. If an Attorney should get involved, you need to notify us immediately. You will be responsible for any denied charges.

Auto and Personal Injury

You are required to supply this office with a copy of the Police Accident Report. You also need to complete our Accident Report. We will bill your medpay on your auto insurance or personal insurance ONLY. Bring in any and all paperwork sent to you regarding your claim as soon as possible. If an Attorney should get involved, you need to notify us immediately. You will be responsible for any denied charges.

I have read and understand **both sides** of this financial policy, and agree to its terms:

_____

Signature of patient/parent Date