Chiropractic
Family Health Center

Dr. Isaiah R Stephan «» Dr. Christina Steenstra

138 Halifax Street; Winslow, ME 04901 «» (207) 873-5161

Date: _____ / _____ / _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ - _____ Work Phone: ( ) _____ - _____ Cell Phone: ( ) _____ - _____

Email Address: _____

Occupation: _____ Place of Employment: _____

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

Name of spouse: _____ Preferred Language: _____ Race/Ethnicity: _____

Who is your primary care physician? _____

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

Name of health insurance: _____ **ID**: _____ Who is primary holder: _____

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: _____

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

If so, did you have x-rays? YES NO If yes, 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 How many packs per day: _____

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 preferred sleeping position? STOMACH BACK LT SIDE RT SIDE

Are you now pregnant? _____ Are you wearing any form of 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

What is your major 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

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 ow

☐Reduce symptoms ☐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:

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

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

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- ○ Doing Hobbies
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- ○ Driving
- ○ Exercise/Sports
- ○ Gardening
- ○ General Mobility
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- ○ Twisting
- ○ Using the phone
- ○ Walking
- ○ Working
- ○ Yard work

This form was reviewed by: _____

Chiropractic
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Dr. Isaiah R Stephan «» Dr. Christina Steenstra

138 Halifax Street; Winslow, ME 04901 «» (207) 873-5161

PATIENT NAME: _____ **DOB:** ____ / _____ / ____

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, explain: _____

2. **Do you feel pain in your chest when you do physical activity?**

   Yes No If yes, explain: _____

3. **In the past month, have you had chest pain when you were not doing physical activity?**

   Yes No If yes, explain: _____

4. **Do you lose your balance because of dizziness or do you ever lose consciousness?**

   Yes No If yes, explain: _____

5. **Do you have a bone or joint problem that could be made worse by a change in your physcial activity?**

   Yes No If yes, explain: _____

6. **Is your doctor currently prescribing medication for your blood pressure or heart condition?** (example: water pills)

   Yes No If yes, explain: _____

7. **Do you know of any other reason why you should not do physical activity?**

   Yes No If yes, explain: _____

Chiropractic Family Health Center

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 to 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 compilation 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.

Printed Name: _____

Signature: _____ **Date:** _____ / _____ / _____

Chiropractic Family Health Center
Dr. Isaiah R. Stephan / Dr. Christina L. Steenstra
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. Isaiah Stephan and/or Dr. Christina Steenstra and whomever they designate as associates to administer chiropractic care as they deem necessary. Chiropractic benefits may be covered by my insurance, however, 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. Isaiah Stephan and/or Dr. Christina Steenstra or an associate to take any x-rays necessary for diagnosis and treatment of

_____ (minor's name). **Relationship to child:** _____

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 Chiropractic Family Health Center to appeal any unfavorable payment decisions on my behalf. I further authorize the release of any information pertinent to 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:_____ / _____ / _____

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FINANCIAL POLICY

Thank you for choosing **Chiropractic Family Health Center (CFHC)** for your chiropractic health care. 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 for at the time of service. For accounts previously in collections, services must be prepaid.

PRIVATE PAY

We accept cash, checks, and credit card. 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 ore-authorized to MasterCard/Visa.

MEDICARE / MEDICARE ADVANTAGE PLAN

CFHC accepts 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 (x-rays, therapies, exercise, **extremity adjustments**, supplements, and supports) if not covered by secondary insurance.

WORKERS' COMPENSATION

You are required to supply CFHC with a copy of the first report of injury filed with your employer. You also need to complete our accident report form. We will complete a Practitioner M-1 form. If your claim is denied, your personal insurance will be billed. You must keep CHFC informed of any changes. Bring in all paperwork sent to you regarding your claim as soon as possible. If an attorney should get involved, please notify us immediately. ***You will be responsible for any charges denied.***

AUTO and PERSONAL INJURY

You are required to supply CHFC with a copy of the police accident report. You also need to complete our Accident Report. We will bill your med pay on your auto insurance or personal insurance ONLY. Bring in all paperwork sent to you regarding your claim along with a **Direction to Pay Medical Benefits form**. If an attorney is involved, please notify us immediately. ***You will be responsible for any charges denied.***

Patient Name: _____ **Date:** _____ / _____ / _____

Patient/Guardian Signature: _____

(Guardian) Printed Name: _____ **Relationship:** _____

INSURANCE

CFHC currently accepts all insurance other than MaineCare/Medicaid. CFHC will bill insurance directly and have you assign payment to CFHC. You are required to complete and sign our insurance questionnaire below and return. ***Insurances requiring referrals from a primary doctor must obtain them as needed.***

You are responsible to pay all uncovered portions of the bill as the time of service. Most insurances **do not** cover supports, orthopedic pillows, or nutritional supplements. You will be charged for these in full upon receipt. Should your insurance 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 company to help expedite the payment process. **If the insurance company does not pay within 90 days, we will transfer the balance to you.** You may attempt to collect reimbursement from them at that point. Should your insurance pay more than expected, your account will be credited. The insurance company may request reimbursement of any such overpayment; this will be patient responsibility.

INSURANCE QUESTIONNAIRE

Patient Name: _____ DOB: _____ / _____ / _____ MALE / FEMALE

Subscriber Name: _____ DOB: _____ / _____ / _____

Patient Address: _____

Patient Phone: (_____) _____ - _____ CELL / HOME / WORK

Insurance Company _____ ID: _____

Effective State Date: _____ / _____ / _____

Have you checked your Chiropractic Coverage? YES / NO **Please obtain this information:**

Name of Representative & Reference for the call: _____ Date: _____ / _____ / _____

Does Policy Cover Chiropractic Care?: YES / NO Coverage Percentage: _____

Does a Deductible Apply? YES / NO Deductible Amount: _____ Has it Been Met? YES / NO

Is there an Exam Copay (CPT 92204) ? _____ Adjustment CoPay _____

Maximum Visit Limit _____ **Authorization Required? YES / NO** PCP Referral Required? YES / NO

Modalities / Therapy: (Ultra Sound CPT 97035 / Interferential CPT 97014) covered: YES / NO

X-Rays performed in office covered: YES / NO

Therapeutic Exercise (CPT 97110) covered: YES / NO

If you are unable to check your insurance coverage CFHC will do so and provide a verification of benefits sheet for you. We will reach out to you with any costs prior to your New Patient appointment.

Chiropractic Family Health Center
138 Halifax Street
Winslow, ME. 04901

Dr. Isaiah R. Stephan
Dr. Christina L. Steenstra

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

Authorization to Release 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: 207-873-5163 or **Mail to**: 138 Halifax Street; Winslow, Maine 04901

Please release the following:

- ☐ Office notes/treatment
- ☐ Current Conditions
- ☐ Current medications list including allergies to medication
- ☐ Xrays within 1 year of this request.

I release the above information for the purpose or purposes of:
(X) Ongoing treatment/aftercare (X) 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 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

ADVANTAGE RADIOLOGY SERVICE

(419) 269-2424 (844) 283-4163

PATIENT _____ CLINIC _____ FILM DATE _____

AGE_____ SEX M ☐ F ☐ SOCIAL SECURITY# ____/____/____ DATE OF BIRTH _____

PATIENT ADDRESS_____ CITY_____ STATE_____ ZIP_____

X-RAY ASSIGNMENT AGREEMENT

I understand that the services of a chiropractic radiologist are being utilized to insure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the clinic where I am receiving care, and that the charges for these services will be submitted to my insurance carrier, Workers' Compensation carrier or State Bureau, and/or to my attorney in the case of personal injury.

In the event that I receive payment for these services, I agree to promptly remit payment to Advantage Radiology Service (ARS).

I assign my insurance benefits and rights to payment to ARS to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company, attorney, and/or any third-party payer. I authorize my treating physician, insurance company, attorney, and/or any third-party payer to provide ARS or their agents with any information concerning my claim, their services, and/or payment for the services provided.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.

SIGNATURE: _____ DATE: _____

WITNESS: _____

PATIENT HISTORY

PATIENT PRESENTATION _____

_____

TRAUMA? YES ☐ NO ☐ EXPLAIN _____

PAST MEDICAL HISTORY _____

_____

MALIGNANCY? YES ☐ NO ☐ DETAILS _____

DIAGNOSIS/CONCERNS/QUESTIONS [NO ICD CODES PLEASE] _____

PLEASE COMPLETE INSURANCE/BILLING INFO ON REVERSE SIDE