WELCOME TO CHIRO-MED & REHAB!

To insure proper case information, please provide us with the following information.
If you need assistance in completing these forms, please ask.

Today's date ______________________

Name ______________________________________

Date of Birth ______________________ ☐ Male ☐ Female SSN: ________________

Mailing Address ______________________________________

City, State, Zip ______________________________________ Home Phone ________________

Email Address ______________________________________

Occupation ______________________________________

Employer ______________________________________ Work Phone ________________

Employer's Address: ______________________________________

Were you referred by ☐ Yourself ☐ Friend ☐ Insurance Carrier ☐ Primary physician ☐ Other physician

Name of person who referred you: ________________________

If different from above, who is your family physician? ________________________

IF WE HAVE COPIES OF YOUR INSURANCE CARDS YOU MAY SKIP THIS SECTION

FINANCIAL :	PRIMARY INSURANCE	SECONDARY PAYER OR RESPONSIBLE PARTY
NAME		
ADDRESS		
CITY,ST.ZIP		
POLICY #		
INSURED NAME		
RELATION		
SOC. SEC. #		
BIRTH-DATE		
GROUP #		
EMPLOYER NAME		

I the undersigned hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process insurance claims. I understand that I am responsible for all charges which may include legal fees, collection fees or other expenses incurred by the provider in collecting my account. I authorize Chiro-Med & Rehab to retain a daily treatment record of services rendered. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

______________________________ Signature

________________ Date

WHAT PROBLEM BRINGS YOU TO SEE US TODAY?

WHEN DID THIS PROBLEM START?

Did it come on: ☐ Suddenly ☐ Built up over several days ☐ Gradually worse over a long time.

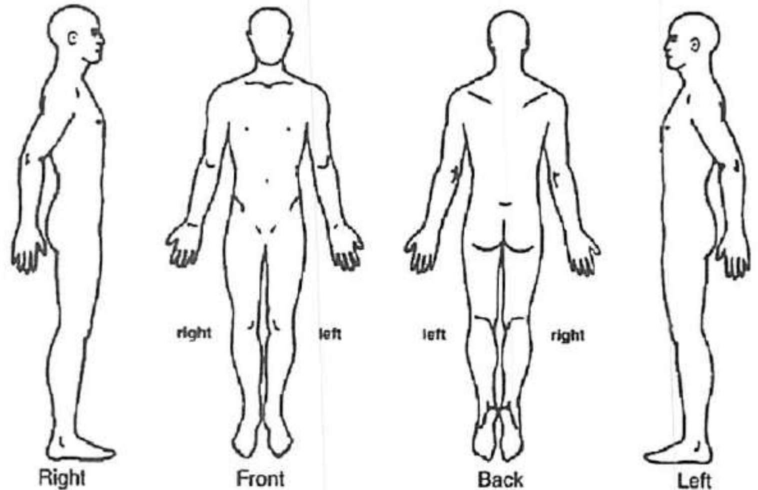
If you were injured was it: ☐ At Work ☐ At Home ☐ Due to Auto Accident ☐ Other Injury

ON THE FIGURES AT THE RIGHT, PLEASE MARK YOUR AREA(S) OF PAIN OR DISCOMFORT. **Circle** the areas (if more than one) of pain and tell us on a scale of 1 to 10, with 1 being light pain to 10 being very severe, how severe is your pain in each area most of the time and how frequent.

AREA 1 pain is (1-10) ___ Constant or Intermittent
At________% of my day

AREA 2 pain is (1-10) ___ Constant or Intermittent
At________% of my day.

AREA 3 pain is (1-10) ___ Constant or Intermittent
At________% of my day



Please help us understand your pain: **Circle the words** for each area that best describes your pain and activity during your day.

Area 1 is:	Worse in AM	At Night	After exertion	It is: Sharp	Stabbing	Dull	Achy	Throbbing	Burning	Tingling
Area 2 is:	Worse in AM	At Night	After exertion	It is: Sharp	Stabbing	Dull	Achy	Throbbing	Burning	Tingling
Area 3 is:	Worse in AM	At Night	After exertion	It is: Sharp	Stabbing	Dull	Achy	Throbbing	Burning	Tingling

I have difficulty with: Walking Sitting Standing Driving a car Sleeping My daily routine Bladder Control Depression

I currently am : Ambulatory without assistance Need to use: Support Brace__________Walker Cane Crutches Wheelchair

Please help us better understand **your personal circumstances** and assist us in providing you customized treatment and care.

I Am Now: ☐ Working Full Time Part Time ☐ Homemaker ☐ Full Time Student ☐ Unemployed ☐ Retired

Occupation: ____________________

☐ On sick leave ☐ On Temp disability ☐ On Full Disability My last day worked was ____________________

Age_______ Single Married Separated Filing for Divorce Divorced

Please feel free to discuss with us any situation in your personal relationships that may affect your recovery.

I Now ○ Smoke____Packs per day Stopped __________ ○ Use Alcohol Type and Amt __________________

○ Consume Caffeine: Type/ Amt __________________ ○ Use recreational drugs __________________

I am now or have in the past been : ○ Addicted to drugs alcohol ○ Treated for alcohol or drug addiction

WOMEN ONLY Can you become pregnant? YES NO | Date of last period __________________ Normal Yes No

If not, why? __________________ | Date of last Mammogram __________________ Normal Yes No

Are you now or could you be pregnant ? ? YES NO | Pap Smear__________________ Normal Yes No

Patient		Primary Intake History

Pertinent History/ Please advise us of any special circumstances, previous tests, therapy or conditions.

Are you allergic to any medications? NO YES (If yes, please list all that you are allergic to below)

If you previously had any of the following procedures, please list the date and place they were performed.

PROCEDURE	DATE(S)	PLACE PERFORMED
X-Rays		
C.T. / MRI		
Myelogram		
Ultrasound		
E.M.G.		
Treatment by Another Physician		
For what?		

PLEASE MARK ANY CONDITION THAT YOU NOW HAVE OR HAVE RECOVERED FROM IN THE RECENT PAST.

Severe headaches / Chest pain / Angina / Kidney Stones / Digestive problems / Hypertension / Renal disease Gout / Stroke / Heart murmur / Diabetes / Arthritis / Epilepsy / Arrhythmia / Endocrine disease / HIV / AIDS Fatigue / Congenital heart disease / Urinary, genital problems / Dizziness / Fainting / Anemia / Reumatic fever / Scarlet fever / Prostate problems / Ulcers / Gall Stones / Sexual dysfunction / Venereal disease / Pancreatitis Shortness of breath / Menstrual dysfunction / Mental Illness / Asthma / Liver disease / Alcohol or Drug problems.

CURRENT MEDICATIONS PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING. *(Prescription and over the counter)*

Name of medication and Strength	# of doses / day

HOSPITALIZATION and SURGERY

PLEASE LIST ALL SURGERY AND ANY PERIODS OF HOSPITALIZATION (give dates)

FAMILY HISTORY: Has anyone in your immediate family (mother, father, grandparents, brothers, sisters, children) had

condition	who?	condition	who?
Heart Disease		Epilepsy	
Hypertension		Glaucoma	
Stroke		Bleeding disorders	
Cancer		Kidney disease	
Diabetes		Thyroid disease	

Do you require special care or have any concerns that might affect your treatment or recovery? NO YES (If yes please describe)

Thank you for assisting us in gathering the information our medical providers need to help determine a personal treatment plan for you. To verify that the information is correct as given to us by you, please affix your signature in the area (x) provided below.

Patient Signature:	*DATE:*

Dear Patient,

Cancellation/ No-show policy:

Please be advised that in the event that you are unable to make your appointment and do not give a 24 hour notice, you may be liable for a $35 cancelation charge. We understand that emergencies happen and will handle each situation as it arises.

Late arrival policy:

Please be aware that we understand things beyond your control can occasionally prevent you from making it to your appointment on time. We typically try to allow a 10 minute grace period, but please understand that the daily schedule may not always allow for that and we apologize if the office is unable to see you. We respect your time and attempt to try our best to always be on time. Late arrivals can create a back up for other patients that may be scheduled after you. We do understand that we ourselves occasionally run behind, so we try our hardest to be as understanding and accommodating as possible. We will not charge for a late arrival, even if it is decided that we cannot see you.

Thank you for your understanding.

X________________________________ Date__________________

Please circle:

Have you been to another Chiropractor, Occupational Therapist, or Physical Therapist with in the past 12 months? **Y / N**

***Failure to notify us of these visits can result in claims being denied and becoming an out of pocket expense to you.**

PLEASE NOTE- MEDICARE/MEDICAID/UN-INSURED PATIENTS:

Medicare and Medicaid insurance plans will not cover a Chiropractic office visit, they will only cover adjustments. Please be advised that if an office visit is rendered, you will be responsible for the charge. The initial office visit (uninsured patients as well) will be $200, and any other office visit rendered after that visit will be $65****INITIAL**________

ADVANCE NOTICE AND BENIFICIARY ACCEPTANCE OF LIABILITY FOR PAYMENT

PLEASE BE ADVISED: Medicare will only pay for services that it determines to be "reasonable and necessary" as stated in their policy or as described under Section 1862 of the Medicare law. If Medicare determines that a particular service, although it would be normally covered, is not reasonable and necessary under current program standards, the Medicare carrier will deny us payment for that service. It is Doctor's opinion that you will benefit from the recommended procedure but under current standards, the items checked below may be denied by the Medicare carrier.

( ) Manual manipulation of the spine / spinal adjustment(s)

(X) All non-spinal services provided by a Chiropractor

(X) All Therapy Services other than spinal manipulation

(x) OTHER: Initial consult, Imaging report of findings, Office visits for new issues or gap in care

Medicare will likely deny payment based on the following reasoning:

(X) Medicare only covers spinal manipulation

(X) All non-spinal manipulation services, provided by a Chiropractor are not covered services

I have been notified by my doctor that Medicare is likely to deny payment for the services identified above and for the reason indicated above. If Medicare denies payment, I agree to be personally responsible for payment of these services. If these or other services rendered to me are deemed payable under Medicare rules and regulations, I request and authorize such benefits be paid either to me or on my behalf to the doctor or practice indicated below.

Signature of Patient ______________ Date ______________ Staff initials ______________

Medicare Policy Number ______________

	MEDICARE WAIVER – CHIROPRACTIC
Patient Name	Chiro-Med & Rehab

CHIRO-MED & REHAB

Medicare/Medicaid Health/Speech Therapy Waiver

Are you currently receiving Home Health Care or Physical Therapy through Home Health or another Provider?

YES NO

Have you received Home Health Care or Physical Therapy through Home Health or another Provider during the current year?

YES NO

Are your or have you received Speech Therapy during the current policy year?

YES NO

Have you previously been treated for your current condition by another provider?

YES NO

I, ______________________________, understand that if I have not been discharged from a home health program prior to beginning outpatient physical therapy. Medicare will not pay the outpatient physical therapy claims at Chiro-Med & Rehab. Therefore, I will be responsible for any charges incurred.

***CHILDREN** with Medicaid Insurance are only allowed 8 visits per condition period. Please notify us if you have been treated for this condition before. Otherwise, you may be liable for charges incurred.

______________________________ ________________

Patient Signature Date

______________________________ ________________

Witness Signature Date

Southwestern
Vermont Health Care

Authorization for Release of Information

Patient Name: ______________________________ Date of Birth: __________ MR#: __________
Print

Address: ____
Print

I hereby authorize SVHC the use or disclosure of my protected health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations. This authorization is valid for 1 year unless otherwise specified.

Name and Address of Persons/Organizations authorized to receive information:
Chiro-Med & Rehab- 345 Elm Street, Bennington, VT 05201; P: 802-753-7930; F: 802-753-7924

Specific description of information that may be used/disclosed and dates of service:

- ☐ X-ray Films and Report
- ☐ Office Notes
- ☐ ER Report
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Operative Note
- ☐ Outpatient Department
- ☐ Other: (Describe) ______________________________

This authorization permits SVHC to disclose my protected health information from my health record with no limitations placed on history of illness, diagnostic or therapeutic information including any treatment for alcohol and drug abuse, psychiatric impairment, HIV/AIDS related illnesses or genetic testing.

The information will be used / disclosed for the following purpose(s):

- ☐ Requested by the patient and for the patient (not necessary to disclose purpose).
- ☐ Insurance claim
- ☐ Other: (Describe) ______________________________

- ☐ I understand that this authorization is voluntary and that I may refuse to sign this authorization. I do not need to sign this form to ensure healthcare treatment.
- ☐ I understand that I may inspect or copy the information used or disclosed.
- ☐ I understand that I may revoke this authorization at any time by notifying SVHC, in writing, except to the extent that:
  1. action has been taken in reliance on this authorization; or
  2. if this authorization is obtained as a condition of obtaining coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

______________________________ __________
Signature of Patient or Patient representative Date:

____
Relationship to patient or representative's authority to act for the patient (if applicable).

Request Received:_______ Date Processed: ______
Date: Date:

☐ Copy of Authorization given to the individual

Initial of person finalizing request: _____
Created date: 4/14/03 Revised date: 5/5/03

Chiro-Med & Rehab
345 Elm Street, Bennington, VT 05201
P: 802-753-7930; F: 802-753-7924

I, ______________________________, DOB __________________
authorize the disclosure of specified information as described below, for continuation of treatment to Chiro-Med & Rehab

Information to be released:

____

____

____

____

Method of release: MAIL / FAX / EMAIL / PHONE

This authorization shall remain in effect from the date of signature until:

__ Specific expiration date ___________________

__ NO EXPIRATION DATE

Signature _____________________________ Date ____________