# Chiro-Med & Rehab

## Chiropractic Medicine
## Orthopedic Rehab

345 Elm Street
Bennington, VT 05201
P: 802.753.7930 / F: 802.753.7924
chiromedoffice@gmail.com / www.cmrehab.net
Office hours: M/Tu/Th: 9A-5P ~ Wed: 9A- 7P ~ Fri: 9A- 12P

Welcome!

Please complete the enclosed forms for your visit with our office.

It is mandatory to have all forms completed prior to being treated. We will be unable to treat you unless every form has been completed and confirmed by the front desk.

Please feel free to submit your forms prior to your appointment via any of the above methods.

You may also text the office phone number with any questions and our front desk will reply promptly. Please note, the ability to respond is only during office hours.

**Please note**- it is IMPORTANT to bring any imaging and reports on a disc for review on your initial visit. Please confirm with the office prior to your visit that you and/or we have this required information. If you do not have it, you may need to return for a follow up visit to review imaging/tests that are pertinent to your care.

Thank you!

-The Chiro-Med team

## 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 _____ * Required for billing *

Occupation _____

Employer _____ Work Phone _____

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.

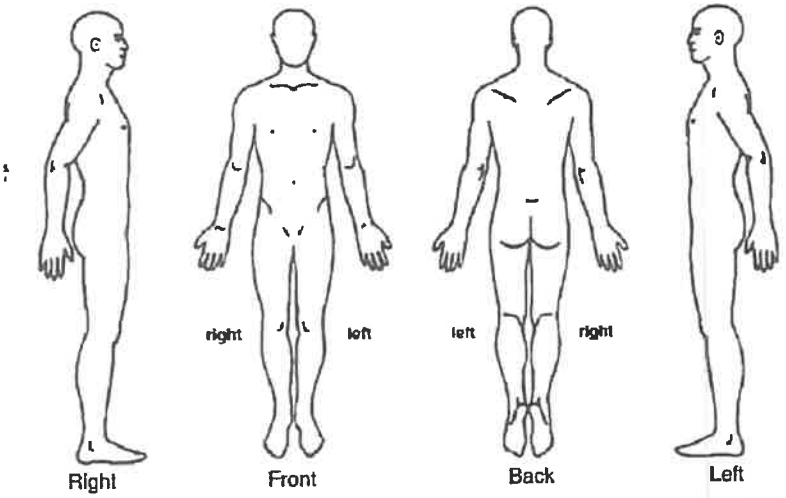
If you were injured was it: ☐ At Work ☐ At Home ☐ Due to Auto Accident ☐ Other Injury

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

**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:*

**Cancellation/ No show policy**

Please be advised that it is this office's requirement to give a business days' notice if you are unable to attend your appointment. If you fail to do so, you will be charged a $35 fee. This fee also applies to no-show occurrences as well as same day cancellations. Cancellations outside of office hours (i.e- a Saturday/Sunday cancellation for a Monday appointment or a cancellation during the week outside of office hours), are not accepted as we will not be able to take the appropriate steps to fill your appointment spot if we are not in the office. We understand emergencies happen, and will handle and will address each event as applicable.

**Late arrival policy**

We understand that things beyond your control often happen and might prevent you from making it to your appointment on time. Our office policy is to allow a 10 minute grace period for such late arrivals. We respect your time and ask that you respect the office's/other patient's time as well. We apologize for the instances where we will not be able to accept a late arrival beyond the 10 minute grace period.

Thank you for your understanding regarding these policies.

Signature:_____ Date:_____

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***For Medicare/ Medicaid patients only****

Medicare and Medicaid will only cover Chiropractic adjustments. They will not cover office visits or any other procedure billed by a Chiropractor. If any other procedure is rendered, you are solely responsible for this charge. This office aims to notify you in advance should a non-covered charge happen. However, if you do not inform the office ahead of your appointment about a change in your symptoms or a new issue that requires an office visit, we will not have the ability to inform you ahead of your appointment regarding the charge. ***Initials*** _____

New patient exam- $200
Existing patient, low complexity office visit/ Imaging review- $80
Existing patient office visit/re-exam or new complaint - $120
Daily treatment- $65 (Visits are based on 30 minute encounter times)

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**Consent to treat a minor**

I, _____, parent or legal guardian

of _____, DOB _____

hereby give consent to medical care by a physician to be necessary for the welfare of my child

while said child is under the care of Chiro-Med & Rehab, and I am not present.

_____ _____

Signature Date

To Our Patients:

As you know, if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill or charge for incidentals. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

We have implemented a **mandatory**, similar policy. You will be required to present a credit card at the time you check in for your appointment. This information will be held securely in our HIPAA compliant billing software until your insurance(s) has paid their portion and notified us of the amount of your share. Once your claim has been processed by your carrier and posted to our system,we will notify you that you will have a charge pending. Any remaining balance owed by you will be charged to your card on file, and a copy of the charge will be mailed/emailed to you if requested.

This will be an advantage to you since you will no longer have to write out and send us checks. It will also be an advantage to us because it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of healthcare down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays, coinsurance, and deductibles that are due at the time of the visit will, of course, still be due at the time of the visit.

If you have any questions about this payment method, do not hesitate to ask.

Sincerely yours,
Chiro-Med & Rehab

I authorize Chiro-Med & Rehab to charge outstanding balances on my account to the following credit card:

Visa / Mastercard / American Express / Discover / Other:_____

Name on card (Please Print)_____

Card#_____ Exp Date:_____

V-Code (3 digits on back):_____ Zip Code linked to card:_____

Email Address:_____

Signature:_____ Date:_____

***Southwestern Vermont Medical Center***

*100 Hospital Drive*
*Bennington, VT 05201*

# Authorization for Release of Information

Patient Name: _____ Date of Birth: _____ MR #: _____
Please Print

Address: _____
Please 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:

_____

_____

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: _____ ☐ Copy of Authorization given to the individual
Date — Date

Initial of person finalizing request: _____

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## Release of information

Name: _____

Date of birth: _____

Telephone number: _____

I authorize the release of requested information for medical care purposes only relating to my treatment at Chiro-Med & Rehab.

Information to be included- office notes, consultation notes, surgical notes, laboratory results, radiology reports and images.

Said information may be released via fax, mail, email and/or phone.

__ This form expires in one year

__ This form does not expire

Signature: _____ Date: _____