# Patient Information Sheet

Name______________________________________ Date________________
Address____________________ City_______________ State____ Zip Code________
Home Phone( )____________ Cell Phone ( )______________________________
Employer Name ______________________ Work Phone ( )________________
E-mail_____________________________ Emergency Contact________________
Social Security Number____-____-_______ Date of Birth___________ Age________
Male / Female Marital Status _______ Spouse ______________________________
Who referred you to this office?__________________________________________

Is this case related to current or previous employment? Y__ N__
Is the condition related to an auto accident? Y__ N__
Is the condition related to another type of accident? Y___N___
Is there another health benefit plan? Y___N___

## Release of Information

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long term authorization card.

Signed_______________________________Date______________________

## Assignment of Benefits

In the event any insurance company is obligated by contractual agreement to make payment to me or to you for the demand by you, I the undersigned patient irrevocably sign and transfer assignment of benefits to Chung & Waggoner Health Center, Inc. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due), I personally owe and agree to pay in a current manner.

Signed_______________________________Date______________________

# CHUNG & WAGGONER HEALTH CENTER

7000 NORTHWEST EXPRESSWAY, STE. H
OKLAHOMA CITY, OK 73132

OFFICE: (405) 773-1113
FAX: (405) 773-1114

## Notice of Privacy Practices

**Privacy Officer: Dr. David B. Waggoner**

Information may be released to the following individuals/organizations: (example: Family members) ____________________________________________

____________________________________________

Information May **NOT** be released to the following individuals/organizations: __________

____________________________________________

You May _____ May **NOT** _____ leave appointment reminders on my message service.

I understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release further information shall remain in force until I revoke it in writing.

I acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Name: ______________________________

Signature: ______________________________ Date: __________

If not signed by the patient, please indicate the relationship: ____________________

Witness: ______________________________

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## Medicare Policy

Dear Medicare patient:

Drs. Chung and Waggoner do accept assignment with Medicare. However, there is a $150.00 to $235.00 deductible depending on your individual Medicare plan to be met each calendar year. After the deductible is met there will be a $5.36 to $8.02 co-pay, depending on your treatment plan, or your individual Medicare Supplement co-pay for the spinal manipulation. These prices are subject to change at any time in accordance with Medicare rules or changes with Medicare.

"Medicare will only pay for services that it determines to be 'reasonable and necessary' under section 1862 (A) (1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service." **Medicare will not pay for examinations, diagnostic studies/x-rays, or physical therapy modalities; therefore any such charges will be your responsibility.** Note:

1. Medicare may only pay for a certain number of chiropractic visits. You are responsible for your entire bill, including any services that Medicare considers NOT ALLOWED or necessary.

2. Medicare can deny any procedures or services for any variety of reasons not mentioned above. For example, Medicare will not pay if they decide a procedure:

   - was not covered for the diagnosis
   - includes more than one billed visit per day
   - exceeds their determination of a treatment plan
   - was for maintenance, prevention, or comfort

**"I have been notified by my physician that he/she believes that, in my case, Medicare is likely to deny payment for the services identified above. If Medicare denies payment for any service throughout the course of my treatment, I agree to be personally and fully responsible for payment. I further understand that any time I am treated at Chung & Waggoner Health Center, Inc. this will apply."**

PRINT PATIENT'S NAME: ______________________________

PATIENT'S SIGNATURE: ______________________ Date: ____________

WITNESS SIGNATURE: ______________________________

A. Notifier: Chung And Waggoner Health Center, INC.

B. Patient Name: C. Identification Number:

# Advance Beneficiary Notice of Non-coverage (ABN)

**NOTE:** If Medicare doesn't pay for D. 98941 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. 98941 below.

| D. | E. Reason Medicare May Not Pay: | F. Estimated Cost |
|---|---|---|
| 98941 | For the treatment of subluxation. | $105.00 |

**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. 98941 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. 98941 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. 98941 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. 98941 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: |
|---|---|
| | |

**CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

# Confidential Patient Case History

Name:______________________________ Date:______________

## CURRENT CONDITION

Please describe the **primary** problem / reason for this visit ______________________________

______________________________

______________________________

______________________________

How and when did symptoms first occur?______________________________

______________________________

______________________________

Is the condition progressively worsening? Yes____ No____ Symptoms: Are constant____ Come and go____

What aggravates your condition? ______________________________

What helps / alleviates your condition?______________________________

Does this condition interfere with: Work___ Sleep___ Daily Routine___ How? ______________

Have you had this or similar conditions in the past?______________________________

Have you had previous chiropractic care?_____ If yes, Name of doctor ______________

Response to treatments ______________________________ Date of last care: __________

List any other doctors seen for these problems______________________________

List previous diagnosis or treatments you have received for present condition: ______________

______________________________

______________________________

List any **secondary / other** complaints: ______________________________

______________________________

Details about above complaints: ______________________________

______________________________

______________________________

## ADDITIONAL HISTORY

List surgical operations and years:______________________________

______________________________

______________________________

______________________________

Have you ever been in an auto accident: Yes / No _____ Approximately how long ago? ______________

Describe ______________________________

List any fractures, trauma, concussion, or hospitalizations you have suffered: ______________

______________________________

Have you ever had mental or emotional disorders? Yes /No___ Describe______________________________

List medications (both over-the-counter & prescriptions). Please indicate name, dosage and duration of use):
*Include NSAIDs, analgesics, muscle relaxants, antidepressant/anxiety, sedatives, hormones, birth control pills, anti-hypertensives, antibiotics/virals/fungals, allergy/sinus medications, ulcer medications...*

______________________________

______________________________

List any medications you are allergic to______________________________

When was the last time you really felt good? ______________________________

List any vitamins or herbs take ______________________________

______________________________

Name: ______________________

# Family History

| | RELATIONSHIP | DESCRIBE |
|---|---|---|
| Cancers | | |
| Heart disease | | |
| Diabetes | | |
| Spinal disorders | | |
| Other | | |

Please check the appropriate boxes for any symptoms which you currently have.

**GENERAL**
- ☐ Allergies
- ☐ Bruise Easily
- ☐ Chronic Cough
- ☐ Dizziness/Fainting
- ☐ Depression
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Itching / Rash
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Tremors

**MUSCULOSKELETAL**
- ☐ Arthritis
- ☐ Bursitis
- ☐ Poor Posture
- ☐ Spinal curvature

PAIN or NUMBNESS in:
- ☐ Low Back
- ☐ Hip or Knee
- ☐ Leg or Foot
- ☐ Neck
- ☐ Shoulder or Elbow
- ☐ Arm or Hand

**GASTRO-INTESTINAL**
- ☐ Abdominal pain
- ☐ Colon Trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult Digestion
- ☐ Gall Bladder Trouble
- ☐ Hemorrhoids
- ☐ Intestinal Parasites
- ☐ Liver Trouble / Jaundice
- ☐ Nausea
- ☐ Vomiting

**EYES/EARS/ NOSE**
- ☐ Asthma
- ☐ Colds
- ☐ Ear aches
- ☐ Ear Noises
- ☐ Eye Pain
- ☐ Failing Vision
- ☐ Gum disease
- ☐ Nose Bleeds
- ☐ Thyroid Problems
- ☐ Sinus Infection
- ☐ Spit / Cough Blood
- ☐ Sore Throat

**CARDIO-VASCULAR**
- ☐ Chest Pain
- ☐ Difficult Breathing
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Poor Circulation
- ☐ Swelling of Ankles/Legs
- ☐ Varicose Veins

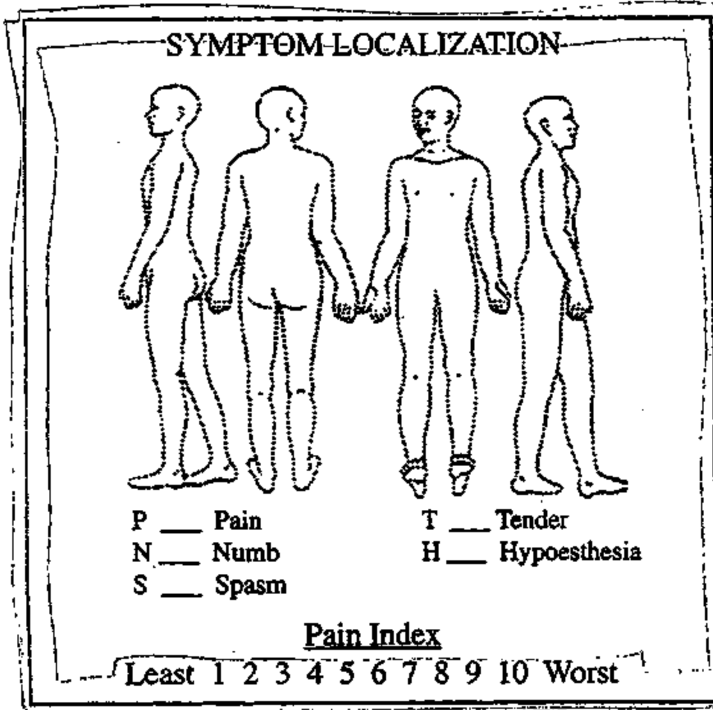
**GENITO-URINARY**
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Uncontrolled Urination
- ☐ Kidney Infection / Stones
- ☐ Painful Urination
- ☐ Prostate Problems
- ☐ Hernia

**FOR WOMEN ONLY**
- ☐ Breast Pain / Tenderness
- ☐ Menstrual Cramps / Pain
- ☐ Excessive Menstruation
- ☐ Hot Flashes
- ☐ Irregular Cycle
- ☐ Menopausal Symptoms
- ☐ Menstrual Low Back Pain
- ☐ Vaginal Discharge

ARE YOU PREGNANT?

☐ Yes ☐ No

SYMPTOM LOCALIZATION



P ___ Pain
N ___ Numb
S ___ Spasm
T ___ Tender
H ___ Hypoesthesia

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

**CHECK THE FOLLOWING CONDITIONS YOU HAVE / HAD:**

| | | |
|---|---|---|
| ☐ Alcoholism | ☐ Epilepsy | ☐ Multiple Sclerosis |
| ☐ Alzheimer's | ☐ Fibromyalgia | ☐ Parkinson's |
| ☐ Anemia | ☐ Gout | ☐ Pneumonia |
| ☐ Arteriosclerosis | ☐ Heart Disease | ☐ Stroke |
| ☐ Cancer | ☐ Hepatitis | ☐ Tuberculosis |
| ☐ Diabetes | ☐ HIV / AIDS | ☐ Ulcers |
| ☐ Emphysema | ☐ Miscarriages | ☐ Venereal Disease |

| HABITS: | Heavy | Moderate | Light | None |
|---|---|---|---|---|
| Alcohol | ☐ | ☐ | ☐ | ☐ |
| Coffee | ☐ | ☐ | ☐ | ☐ |
| Tobacco | ☐ | ☐ | ☐ | ☐ |
| Exercise | ☐ | ☐ | ☐ | ☐ |
| Sleep | ☐ | ☐ | ☐ | ☐ |
| Appetite | ☐ | ☐ | ☐ | ☐ |

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home)

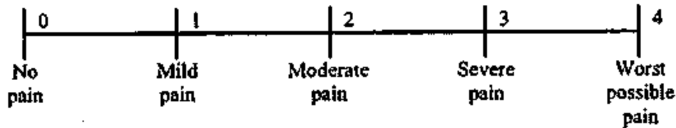
Name: ______________ Phone: ______________ Relationship: ______________

# Functional Rating Index

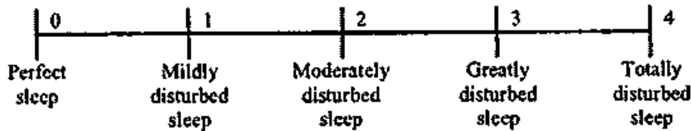
For use with <u>Neck and/or Back Problems</u> only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

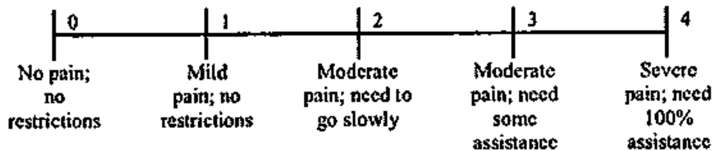
### 1. Pain Intensity



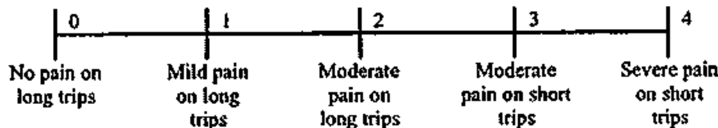

### 2. Sleeping



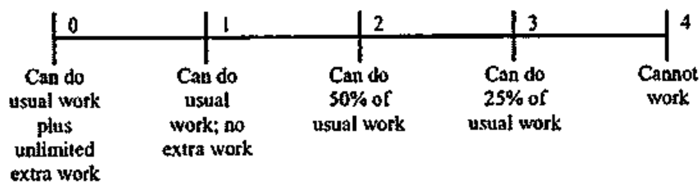

### 3. Personal Care (washing, dressing, etc.)



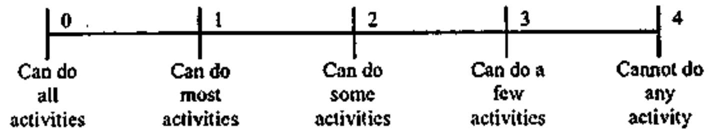

### 4. Travelling (driving, etc.)



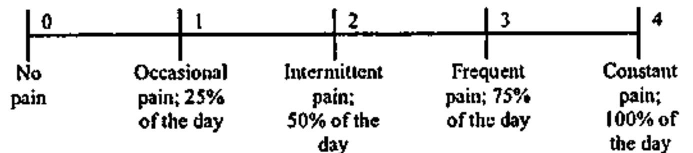

### 5. Work



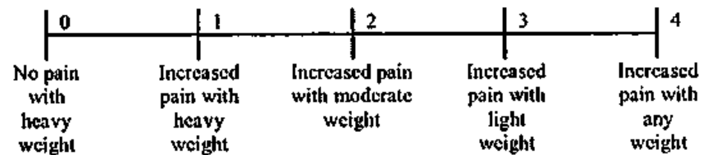

### 6. Recreation



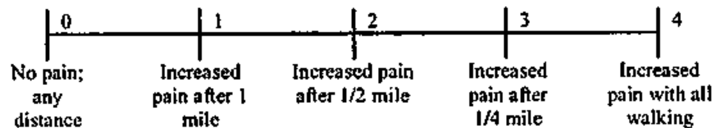

### 7. Frequency of Pain



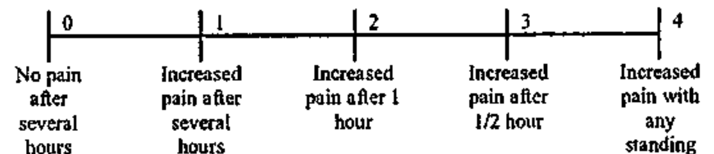

### 8. Lifting




### 9. Walking




### 10. Standing




______________________________
**Patient's Signature**

______________________
**Date**

**<u>For Office Use Only:</u>**

Practitioner ID#: ______________________

**Total Score** ____________ **/ 40**

Clinical Diagnosis Codes:

Patient ID#: ______________________

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