Case #_____

PATIENT INFORMATION

Welcome to our office! Please allow our staff to photocopy your insurance cards.

PLEASE PRINT CLEARLY

Marital Status: S M W D

Full name_____Age_____Birthdate_____ Gender: **M F**
Address_____City_____State_____Zip_____
Home Phone_____-_____-_____SS#_____-_____-_____Email address_____
Cell Phone _____
Employer_____Occupation_____Work Phone_____-_____-_____
Work Address_____City_____ State_____Zip_____
Primary care physician_____Physician Phone_____-_____-_____
Spouse's Employer_____Occupation_____Work Phone_____-_____-_____
City_____State_____Zip_____Insurance Company_____
Primary care physician?_____Phone_____-_____-_____
How did you find out about our office? □ Referral from_____ □ Yellow Pages
□ Other_____
Describe your current problem and how it began_____
_____
_____

Circle all which applies:

Smoking Status: Never Former Current every day smoker Current occasional smoker

Preferred Language: English French Spanish German Other: _____

Race: American Indian or Alaska Native Asian Black or African American
Native Hawaiian or Other Pacific Islander White Other_____

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Is this? □ Work Related □ Auto Related □ N/A Date of accident/onset _____

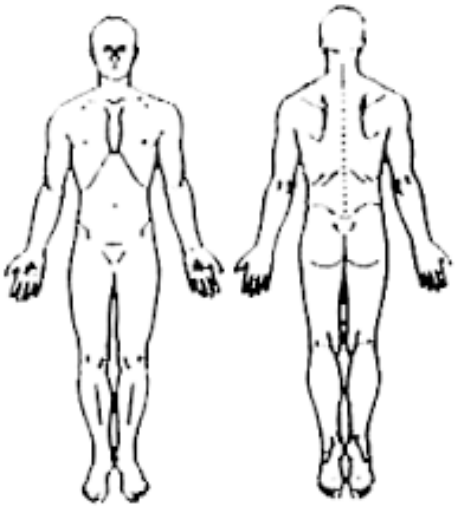
Current Complaint (How you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain → Unbearable pain

How often are your symptoms present?
□ Morning □ Noon □ Night □ Constant □ Other: _____
_____
Have you had any X-RAYS, MRI, CT SCAN? □ No □ Yes Dates_____
_____
What areas were taken? _____

Please mark X on picture where you have pain or symptoms.



READ CAREFULLY BELOW.

ACCEPTANCE AS PATIENT

I understand and agree that Dr. Joseph A. Barone, Dr. Joseph T. Barone, and Dr. Alison Roberts (Barone) have the right to refuse accepting me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient. Referral may be necessary.

PRIVACY

I authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and herby release him/her of any consequences thereof. **I (we) agree that all the above information is complete and accurate. The bottom agreements are also understood.** A photostatic copy of this agreement shall serve as the original.

I authorize the above doctors to discuss my care with my spouse. □Yes □ No □ Other _____

Patient's Signature_____Date_____

Spouse's or Guardian's Signature_____Date_____

REVIEW OF SYSTEMS

NAME_____AGE_____DATE_____

Do You Currently Have Any Of The Following? Circle only the "YES'S" that apply

Integument System

Skin Rash	Y	N
Skin lesion	Y	N
Changes in Skin Color	Y	N
Itching (pruritus)	Y	N
Hair changes	Y	N
Nail changes	Y	N

Endocrine System

Hormone problems	Y	N
Hot flashes	Y	N
Thyroid problems	Y	N
Hormone therapy	Y	N
Growth abnormalities	Y	N
Metabolism changes	Y	N

Digestive System

Abdominal pain	Y	N	Rectal bleeding	Y	N
Nausea	Y	N	Jaundice	Y	N
Vomiting	Y	N	Abdominal distention	Y	N
Constipation	Y	N	Cramping	Y	N
Diarrhea	Y	N	Lump/mass	Y	N

Cardiovascular System

Chest pain	Y	N	Changes in skin color	Y	N
Irregular heartbeat	Y	N	Stroke (full or pin)	Y	N
Shortness of breath	Y	N	Dizziness	Y	N
Fainting	Y	N	Cool hands or feet	Y	N
Fatigue	Y	N	Varicose veins	Y	N
Swelling of legs	Y	N	Mitral valve problems	Y	N

Pulmonary System

Coughing	Y	N
Phlegm/expectorant	Y	N
Coughing up blood	Y	N
Shortness of breath	Y	N
Wheezing	Y	N
Blue skin (cyanosis)	Y	N
Chest pain	Y	N

Musculoskeletal System

Stiffness	Y	N
Popping noises	Y	N
Joint pain	Y	N
Weakness	Y	N
Limitation of movement	Y	N
Extremity deformities	Y	N
Difficulty walking	Y	N

Nervous System

Partial paralysis	Y	N	Lack of coordination	Y	N
Complete paralysis	Y	N	Psychiatric disorders	Y	N
Headache	Y	N	Speech abnormalities	Y	N
Are you right-handed?	Y	N	Visual disturbances	Y	N
Loss of consciousness	Y	N	Are you left-handed?	Y	N
Dizziness	Y	N	Gait disorders	Y	N
Memory loss	Y	N	Tremors	Y	N
Numbness	Y	N	Tics (spasms)	Y	N
Weakness	Y	N	Sensory changes	Y	N
Depression	Y	N	Mood changes	Y	N

NAME_____AGE_____DATE_____

Genital/Urinary System

Pain during urination	Y	N
Changes in urine flow	Y	N
Lump or mass in groin	Y	N
Kidney stones	Y	N
Chronic bladder infections	Y	N
Genital itching	Y	N
Changes in urination frequency	Y	N
Change in urine color	Y	N

Special Senses

Visual problems	Y	N
Hearing loss	Y	N
Loss of balance	Y	N
Loss of taste	Y	N
Loss of smell	Y	N
Loss of touch sensation	Y	N
Temporary vision loss in one eye	Y	N

Reproductive System

Male Only

Testicular pain	Y	N
Prostate problems	Y	N
Infertility	Y	N
Impotence	Y	N
Discharge	Y	N
Lump or mass	Y	N

Female Only

Abnormal vaginal bleeding	Y	N
Painful menstruation	Y	N
Breast lump/mass	Y	N
Vaginal discharge	Y	N
Nipple discharge	Y	N
Infertility	Y	N
Abnormal periods	Y	N

Male pattern baldness Y N

Head and Neck Region

Headaches	Y	N	Ringing in ears	Y	N
Neck stiffness	Y	N	Ear pain	Y	N
Neck lump/mass	Y	N	Ear discharge	Y	N
Eye pain	Y	N	Ear itching	Y	N
Eye discharge	Y	N	Nasal discharge	Y	N
Eye redness	Y	N	Sinus trouble	Y	N
Double vision	Y	N	Bad breath	Y	N
Dry eyes	Y	N	Nasal obstruction	Y	N
Excessive tearing	Y	N	Snoring	Y	N
Spinning sensation	Y	N			

Blood, Lymphatics, Immunology, Allergy

Anemia	Y	N	Frequent illness	Y	N
Iron deficiency	Y	N	Immunity problems	Y	N
Clotting problems	Y	N	Allergies	Y	N
Bruise easily	Y	N	Take allergy shots	Y	N
Swollen lymph nodes	Y	N			

Doctor's Notes_____

_____

_____

_____

_____

I certify that the above information is complete and accurate. I agree to notify the doctor of any changes in my health condition, health care plan, or coverage.

Patient's Signature_____Date_____

Case #_____

PATIENT HEALTH SURVEY

NAME_____AGE_____DATE_____

Please just circle the "yes's which apply

Have you ever (at any time) experienced any of the following?

Difficulty urinating	Y	N	Claustrophobia (fear of small spaces)	Y	N
Loss of bowel control	Y	N	Spinal surgery	Y	N
Temporary loss of vision, one eye	Y	N	Common cold/flu	Y	N
Blood in urine	Y	N	Breast removal	Y	N

Have you ever been diagnosed with or told you have one of the following?

Stroke	Y	N	Detached retina	Y	N
Partial or complete paralysis	Y	N	Rheumatoid arthritis	Y	N
TIA's (pin or mini strokes)	Y	N	Drop attacks (collapsing, but not fainting)	Y	N
Heart Attack	Y	N	Slipped disc	Y	N
Abdominal Aortic Aneurism	Y	N	Herniated disc	Y	N
High blood pressure	Y	N	Prostate disease	Y	N
Bleeding disorders	Y	N	Blood in stool	Y	N
Hardening of the arteries	Y	N	Cancer	Y	N
Osteoporosis	Y	N	AIDS	Y	N
Fractured/broken vertebra	Y	N	Kidney disease	Y	N

Do you currently have, or could you be, any of the following?

Pregnant	Y	N
Taking birth control pills	Y	N
Receiving hormone therapy	Y	N
Male Female		
Receiving chemotherapy	Y	N
Receiving radiation therapy	Y	N
Taking blood thinners	Y	N
A heavy smoker (1 or more packs/day)	Y	N
Surgical/medical implanted devices:		
Aortic clips	Y	N
Brain clips	Y	N
Artificial heart valves	Y	N
Rods, pins, screws	Y	N
IUD	Y	N
Surgical clips/wires	Y	N
Shunt	Y	N
Neuro-stimulator	Y	N
Dentures	Y	N
Pacemaker	Y	N
Hearing aid	Y	N
Insulin pump	Y	N
Joint replacement	Y	N
Cochlear implants (ear)	Y	N
Other implanted devices:		
Metal fragments (head, eye, skin)	Y	N
Bullets/shrapnel	Y	N
Body piercing	Y	N
Tattoos	Y	N

In the past 14 days, have you Experienced any of the following?

Head or neck pain unlike anything before?	Y	N
Nausea	Y	N
Vomiting	Y	N
Vertigo	Y	N
Difficulty walking	Y	N
In-coordination	Y	N
Numbness or other sensory complaints	Y	N
Loss of consciousness	Y	N
Double vision	Y	N
Blurred vision	Y	N
Tinnitus (ringing in the ears)	Y	N
Speech problems	Y	N
Clumsiness	Y	N
Memory Loss	Y	N
Travel by car/Truck long distances for job	Y	N
Personality changes	Y	N
Fever	Y	N
Recurrent headaches	Y	N
Diarrhea	Y	N
A sore that does not heal?	Y	N
Skin rash/infection	Y	N
A major fall	Y	N
A minor fall	Y	N
An auto accident	Y	N
A work injury	Y	N
Loss of strength	Y	N
Pain during bowel movements	Y	N
Head trauma	Y	N
Abnormal period	Y	N

Doctor's use:

I certify that the above information is complete and accurate. I agree to notify the doctor of any changes in my health condition, health care plan, or coverage.

Patient's Signature_____Date_____

PATIENT CONSENT FORM

Medical doctors, Chiropractic doctors, and Osteopaths that perform manipulation are required by law to obtain your informed consent before starting treatment.

I _____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving hands and instruments to induce movement of the joints and soft tissues.

Nature of the adjustment

The Chiropractic adjustment is a high velocity low amplitude thrust administered to reduce inflammation along a spinal nerve root. These irritations are known as subluxations. Analysis consists of hands on motion palpation and soft tissue palpation which may involve palpation of the neck, back, gluteus muscles, and extremities. Adjustments are delivered in low force by hand, instrument, light traction or drop pieces from the table. Ancillary therapy, nutrition, and exercises may also be used help stabilize areas involved and to further reduce inflammation.

Risks

Although chiropractic adjustments are 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 and I freely assume the following risks:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the beginning of treatment.

Drowsiness: Temporary symptoms like dizziness, nausea, and drowsiness can occur but are relatively rare.

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

Vasculature Injury: Although vascular injury happens with some frequency in our world, injury from chiropractic adjustments are debatable and rare but must be mentioned. I am aware that nerve or brain damage including stroke is reported to occur 1 case per 400,000 -1,000,000 adjustments. Once in a million is about the same chance as getting hit by lightening.

Ancillary Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

Treatment Results

Chiropractic care serves to: break up adhesions along the spine and extremities, reduce pain, relax musculoskeletal tissues, and restore ranges of motion. By restoring function and reducing inflammation of the nervous system in this way it has been shown to begin the natural healing of local tissues and have a positive effect on the physiology and health of the patient. I understand the beneficial effects associated with these treatment procedures mentioned above. However, I appreciate there is no certainty that I will achieve these benefits. I understand that all physiological processes involving tissue repair involve time to heal. I understand the typical healing time for an individual may vary widely from weeks to months or more depending on the condition. I understand symptoms are usually the last signs to come and the first to leave under care. I understand pain often leaves relatively quickly but there are still underlying problems/ pathologies whether or not I am experiencing symptoms. I understand only the doctor has the knowledge and training to identify these and to officially discharge me from active care. I understand any early termination of active care without the doctor's direct approval can result in less than optimal results and may lead to the worsening of the pathologies involved and ultimately my pain and or condition. I understand that if I terminate my care early I am relieving the doctor of all responsibility of my condition. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons appointed by the doctor.

Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology; produce inadequate or short-term relief, undesirable side-effects such as: increased healing time, liver/heart/kidney pathology, and gastrointestinal bleeding. Furthermore, there is the potential for physical or psychological dependence and or the use of may have to be continued indefinitely. Some medications may involve even more serious risks.

Surgery: Surgery may be necessary for joint stability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, prolonged recovery, short term relief only, and failed back surgery syndrome.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increases pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment from the doctor or interpreter. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Patient's Signature_____Date_____ Doctor's Signature_____Date_____

Guardian/Interpreter' Signature_____Date_____

Late Cancellation / Missed appointment Policy - Updated Summer 2023

1. **REMINDERS**: Please note that we make every effort to remind you of your appointment with two emails and an automated call. Please remember that this is a courtesy and that you should not depend on these reminders to know when your appointments are, because the emails can go to junk or the calls may come up as spam, or your voicemail may be full.
2. **NOTICE**: If you are unable to attend an appointment for any reason, 24 hour advance must be given. This gives us the opportunity to offer the appointment to another patient in need of chiropractic attention. We understand that emergencies arise, so we will take this into consideration.
    - Failing to give notice will result in a $65 fee automatically charged to your card on file. This fee is not covered by insurance. If the card declines, you will supply a valid method of payment to pay the fee before scheduling your next appointment.
    - Three or more No Shows or Missed Appointments may result in the patient being released from care. We have the right to dismiss from care at any time.
3. **LATE ARRIVALS**: We take your time seriously, so we only ask that you return the favor.

    - If you are running late for your appointment, please call the office to reschedule. Chiropractic appointments are only 15 minutes, so even 5 minutes late will be considered a missed appointment, with the accompanying $65 charge.

    - On occasion, we may be able to work-in late arrivals; however, this is at the discretion of our staff.

Signature: _____ Date:_____

I understand the No Show / Late Cancellation Policy and authorize Barone Family Chiropractic to charge my credit card on file if I am late or didn't give 24 hour notice.

Patient Financial Responsibility

It must be clearly understood that health insurance contracts are between you and your insurance company. You are responsible for understanding your chiropractic coverage, and for paying any amount owed per insurance remittances.

- We bill your insurance for your convenience, however the patient is required to provide the most accurate and updated information regarding insurance.
- It is always an option to pay the full claim amount and bill your insurance independently.

BEFORE YOUR FIRST APPOINTMENT: We encourage you to call your insurance company regarding your benefits and eligibility. Please ask these questions:

1. Do I need a referral or preauthorization? (which you are responsible for obtaining through your primary care provider prior to scheduling initial appointment)
2. How many visits am I allowed?
3. Do I have a deductible, how much is it, and does it apply?
4. Do I have a copay or coinsurance, and how much is it?

_____ I understand that the federal Healthcare Information Portability & Accountability Act (HIPAA) restricts the office's ability to verify patient information & coverage. Therefore, I understand that it is my responsibility to obtain the relevant information and understand my coverage, and that although Barone Family Chiropractic attempts to contact my insurance company, it is not the responsibility of Barone Family Chiropractic to know my benefits and eligibility. I am responsible for any charges incurred if the information provided is not correct or updated.

I understand that is my responsibility to obtain a referral (if applicable) from my PCP before my first visit, because without one, my insurance will not pay for any services and I will be financially responsible for the balance in full.

I understand that while my insurance may confirm my benefits, confirmation of benefits does not guarantee payment and that I am responsible for any unpaid balance. Questions about non-payment should be directed to my insurance company.

ADVANCED BENEFICIARY NOTICE OF NON-COVERAGE

I understand that I, _____, am financially responsible for paying what my insurance company states as my responsibility. I am also responsible for any and all charges that may accrue at this office. These charges include but are limited to the following:

- Exam fees/treatments not covered by my insurance (for medicare patients)
- Deductibles (the amount I pay before my insurance/copay kicks in)
- Copay/Coinsurance (my portion of covered services)
- Denied or non-covered services
- Fees for missed appointments, late cancelations and late arrivals - $65
- Extremity adjustments (joints outside of the spine: shoulder, hip, arm, leg, etc.) $40
- Treatments for the jaw (TMJ) - $50
- Ultrasound therapy - $25

I understand that copays are due at the time of service and that Barone Family Chiropractic does not offer payment plans.

I understand that I have the right to dispute any billing. I understand that errors can occur and it is my responsibility to contact the office if I feel that an error has been made.

Signature: _____ Date: _____

Insurance Info & card on file form

Are you here due to an injury or auto accident? If so, please inform the secretary so they can give you the correct forms to fill out.

Primary health insurance company:	
ID #:	group #:
Plan year start date:	Chiropractic visits allowed per plan year:
Deductible amount:	Does it apply?: Yes / No

Secondary health insurance company (if applicable):	
ID #:	group #:

_____ I understand that I am required to leave a means of payment on file with Barone Family Chiropractic in order to reserve appointments and receive treatment. I understand that my information is safe on an encrypted server. I also authorize Barone Family Chiropractic to charge my card for any fees accrued and services rendered.

Name as appears on credit card:		
Credit Card Number:		
Expiration Date:	CVV:	Zip Code:

Signature: _____ Date:_____