WELCOME TO FALLS CHIROPRACTIC AND INJURY!

PATIENT INFORMATION (Most of the information below is required for insurance purposes)

DATE: _____ / _____ / _____

FIRST NAME: _____ M.I.: _____ LAST NAME: _____

DATE OF BIRTH: _____/_____/_____ CALLED NAME / NICKNAME: _____

ADDRESS: _____ SUITE OR APT #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE:(_____) _____ - _____ CELL PHONE:( ) _____ - _____Text ok? Y N

WORK NUMBER:(_____) _____-_____ (for **emergency** use only)

GENDER: (please circle one) MALE FEMALE

MARITAL STATUS:(please circle one) SINGLE MARRIED OTHER: _____

SOCIAL SECURITY #: _____ - _____ - _____

DRIVERS LICENSE #: _____ STATE ISSUED_____

WORK STATUS:(please circle one) EMPLOYED FULL-TIME STUDENT PART-TIME STUDENT

EMAIL _____@_____

INSURED INFORMATION (**Required information if you, the patient, are NOT the policyholder)**

Patient's relationship to the policyholder: (please circle one) Spouse Child Other _____

First name_____ M.I._____ Last name _____

Social Security # _____ - _____ - _____ Date of Birth _____ / _____ / _____

Gender: (please circle one) Male Female

Referred By: _____

For continuity of care, we would like to send your primary care physician a copy of your initial exam/visit note and x-ray report (if applicable). Please provide your doctor information below:

Doctor Name_____

Practice name: _____

Address/Location name:_____

Phone #:(____) _____-_____ Fax: (_____)_____-_____

_____ ***(Initial here) In providing the information above, I acknowledge and consent to the release of this information to my selected primary care physician/office.***

_____ (***Initial Here***) ***In reading this, I acknowledge that I have been informed that a most recent copy of the HIPAA Notice of Privacy Practices is available for me to review or receive a copy if I request one. I understand this office follows all current HIPPA compliance requirements.***

Patient Health Questionnaire (PHQ)

Patient Name_____

HISTORY OF PRESENT ILLNESS (99203: min of 4,99213:1-3)

1. Describe your *CURRENT* symptoms_____
- 2.When did your symptoms start (This *CURRENT* episode) _____

3. How did your symptoms begin? (I.E woke up with it, bent over, gradually etc...) _____

_____

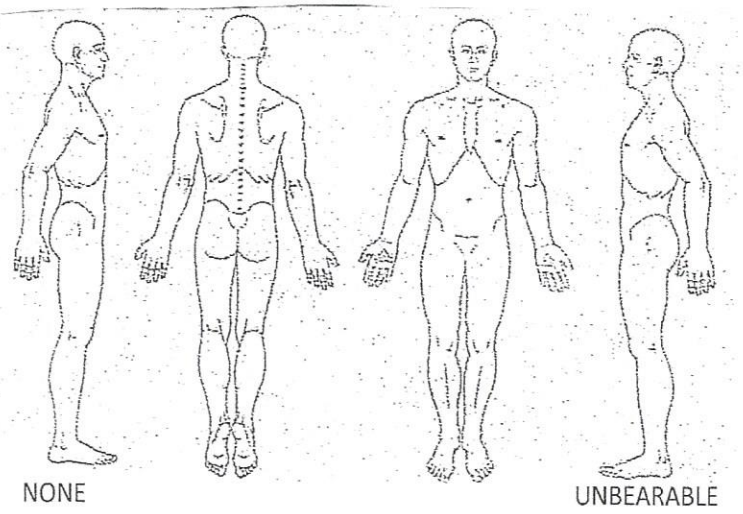
- On the body outline below, please indicate where you have pain or other symptoms: ↓↓↓↓:

- 4. 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)

- 5.What describes the nature of your symptoms:

____ Sharp ____ Shooting ____ Dull ache
____ Burning ____ Numbness ____ Tingling



NONE UNBEARABLE

- 6. Indicate the average intensity of your symptoms: 0 1 2 3 4 5 6 7 8 9 10

7. How much has the pain interfered with your normal activities of daily living, both home and work if applicable:

____ Not at all ____ A little bit ____ Moderately ____ Quite a bit ____ Extremely

- 8. What makes your symptoms WORSE? _____

- 9. What makes your symptoms BETTER? _____

10. What is your occupation? (helps determine mechanics related to issue) _____
____ Full Time ____ Part Time ____ Self Employed ____Unemployed ____Off work ____Other
11. Have you had similar symptoms in the past? ____ YES ____ NO

12. If you have received treatment in the past, who did you see? ____ This office (pprox.. when?) _____
____Medical Doctor ____Physical Therapist ____ Other Chiropractor ____ Other (_____)

13. Have you seen anyone else for this episode of symptoms? ____Medical Doctor ____ Other Chiropractor ____Other

What treatment did you receive and when? _____

What tests have you had for your symptoms and when were they performed? ____XRAY, Date_____

____ CT SCAN, Date _____ ____MRI, Date _____ Other _____

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

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

Review of Systems: ***Please check box if applicable, check NO if none please***
(99203: 2 pertinent, 99213: 1 pertinent)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											

Past Medical History:

PSFH (99203: 1 pertinent)

List all current prescribed (INCLUDE Dosage and Frequency), over the counter medications and supplements: _____

_____

_____

_____

(Continued next page please)

Height: _____ Weight: _____

Allergies: No Known Allergies ____ Latex ___ Medication (name) _____
Other allergy _____

List all surgeries in your lifetime and approx. year:_____
_____

List all serious illness in your lifetime:_____
_____

List all significant trauma or accidents in your lifetime: _____
_____

Please include approximate dates/year on the above listed

Family Medical History for Heredity and Risk:

Indicate if an immediate family member (parents, grandparents, sibling) currently has or has had any of the following:

__ Diabetes __ Scoliosis __ Lupus __ Cancer Relationship to you?:
_____

Social History:

Alcohol Usage	____ frequently	____ occasionally	____ socially	____ never
Tobacco	____ frequently	____ occasionally	____ socially	____ never
Exercise	____ frequently	____ occasionally	____ sporadically	
Exercise Type	____ walking	frequency/distance _____		
	____ running	frequency/distance _____		
	____ swimming	frequency/laps _____		
	____ weights	type and reps_____		
	____ classes	type and frequency _____		

Other concerns or issues you would like to address:

_____

_____

PATIENT SIGNATURE: _____

PATIENT NAME PRINT: _____

Office use ONLY please: Blood Pressure _____/_____ Pulse _____ Temp _____

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

INFORMED CONSENT FORM

PATIENT NAME: _____ DATE: _____

To the patient: Please read this entire document prior to signing it. It is very important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment
The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment
As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

-spinal manipulative therapy	-palpation	-range of motion testing	-orthopedic testing	-vital signs
-muscle strength testing	-postural analysis	-neurological testing	-myofascial release	
-hot/cold therapy	-electrical stimulation	-radiographic studies	-mechanical traction	

The material risks inherent in chiropractic adjustment.
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.
Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.
Other treatment options for your condition may include:
- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.
Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD THE ABOVE.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____	**Richard A. Laviano D.C.**	**Natalia Lopez Vazquez D.C.**
Patient Name Print	**Doctor Name Print**	**Doctor Name Print**
_____	_____	_____
Patient/Guardian Signature	**Doctor Signature**	**Doctor Signature**
_____	_____	_____
Date	**Date**	**Date**

MEDICARE FINANCIAL POLICY AGREEMENT AND INFORMATION

TO MAKE DEALING WITH MEDICARE AS SIMPLE AS POSSIBLE WE HAVE ESTABLISHED THE FOLLOWING GUIDELINES. PLEASE KEEP IN MIND THAT MEDICARE REGULATIONS CHANGE FREQUENTLY AND THEREFORE THESE GUIDELINES MAY BE UPDATED.

- Medicare policy states "office visit/exam and x-rays in a chiropractic office are not covered benefits". "Chiropractic therapies are not a covered benefit". The office exam may be required. **PLEASE NOTE**: ***It is routine and required to perform and charge for an exam if you are a new patient, there is a new incident that has occurred or you have not been seen for a period of time. A 3-month to 3-year period will require an established patient office exam charge and 3 years or more requires a new patient exam charge. This is required by malpractice insurance, the NC Board of Chiropractic Examiners and insurance companies. We do offer an at time of service discount on the non-covered service(s).***
- The 2020 Calendar year Part B deductible amount is $198.00.
- We are a participating provider with Medicare. That means we will bill Medicare directly and write off the difference between what we normally charge and Medicare's allowed amount. We will follow all Medicare guidelines regarding chiropractic.
- We do file initial secondary insurance claims for those claims that do not automatically cross over from Medicare. The patient is always ultimately responsible for any deductible, co pay or non-covered service amounts. These may be collected at the time of service. We DO NOT re-bill or call your secondary insurance to check claim status. That is the responsibility of you, the insured. Please keep all your receipts for these cases.
- If you have any questions regarding Medicare's coverage of chiropractic benefits or this form, please feel free to ask us. We are more than happy to help you understand these guidelines and answer any questions you may have.

BENEFIT ASSIGNMENT, AUTHORIZATION TO RELEASE MEDICAL RECORDS AND AKNOWLEDGMENT OF OFFICE POLICY.

I Hereby assign the benefits that I am eligible to receive for the care rendered in this office, to the office of Falls Chiropractic and Injury.
I authorize Falls Chiropractic and Injury to release any personal information, per HIPPA guidelines, to Medicare to facilitate payment of claims.
By my signature on this form, I acknowledge that I have reviewed and understand the contents of this form and agree to pay Falls Chiropractic and Injury any deductible, co pay or non-covered service amounts.

_____ _____
PATIENT SIGNATURE DATE

PATIENT NAME PRINTED_____

MEDICARE REPLACEMENT FINANCIAL POLICY AGREEMENT AND INFORMATION

TO MAKE DEALING WITH MEDICARE AS SIMPLE AS POSSIBLE WE HAVE ESTABLISHED THE FOLLOWING GUIDELINES. PLEASE KEEP IN MIND THAT MEDICARE REGULATIONS CHANGE FREQUENTLY AND THEREFORE THESE GUIDELINES MAY BE UPDATED.

- Medicare policy states "office visits and x-rays in a chiropractic office are not covered benefits". "Chiropractic therapies are not a covered benefit". The office visit may be required. **PLEASE NOTE**: ***It is routine and required to perform and charge for an exam if you are a new patient, there is a new incident that has occurred or you have not been seen for a period of time. A 3-month to 3-year period will require an established patient office exam charge and 3 years or more requires a new patient exam charge. This is required by malpractice insurance, the NC Board of Chiropractic Examiners and insurance companies. We do offer an at time of service discount on the non-covered service(s).***
- Medicare Replacement Policy's follow standard Medicare guidelines as stated above
- Medicare Replacement plans usually have a co pay. At times, this co pay is more than the allowed amount by Medicare so you will pay the service in full at the allowed amount. Some plans only require the 20% of the allowed amount and your co pay may be less. We will follow all Medicare guidelines regarding chiropractic.
- The patient is always ultimately responsible for any deductible, co pay or non-covered service amounts. These may be collected at the time of service.
- If you have any questions regarding Medicare's coverage of chiropractic benefits or this form, please feel free to ask us. We are more than happy to help you understand these guidelines and answer any questions you may have.

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By my signature on this form, I acknowledge that I have reviewed and understand the contents of this form and agree to pay Falls Chiropractic and Injury any deductible, co pay or non-covered service amounts.

_____ _____

PATIENT SIGNATURE DATE

PATIENT NAME PRINTED _____

FALLS
Chiropractic and Injury
6009 Falls Of Neuse Rd, Raleigh, NC 27609
PH: (919) 876-9472 FAX: (919) 876-9478

REQUEST FOR RECORDS AND/OR IMAGES

DATE:_____ / _____ / _____

I hereby authorize:
Doctor or Facility name: _____
Address _____

Phone #:( )_____-_____ Fax #: ( ) _____ - _____

To release my medical records, radiology reports and/or images to Falls Chiropractic & Injury.
Please release the following health information via fax unless otherwise indicated below:

_____ X-Ray Films **with** Report (please fax report and then mail or courier images CD)
_____ **MRI Scan CD with** report (please fax report and then mail or courier images CD)
_____ **H&P, ov notes, labs, radiology reports**
_____ All ED or visit records in regards to personal injury or MVC on _____
Other _____

Purpose of release is sharing with another healthcare provider unless indicated:
_____

Date(s) of Service: _____

Patient Name (printed): _____

Patient date of birth: _____/_____/_____ Patient SS#: XXX-XX-_____

PATIENT SIGNATURE: X_____

PLEASE FAX ALL RECORDS TO **(919) 876-9478**.
IF IMAGES ARE REQUESTED, PLEASE SEND THOSE BY MAIL.

IF YOU CANNOT COMPLY WITH THIS REQUEST PLEASE NOTIFY US IMMEDIATELY. THANK YOU!