P.O. Box 509001, San Diego, CA 92150-9001
California Only Fax: 877.427.4777 All Other States Fax: 877.304.2746

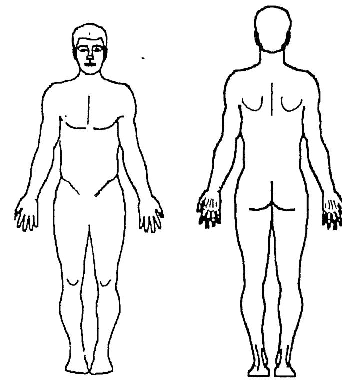
INITIAL HEALTH STATUS
Chiropractic

Patient Name________________________ Birthdate______________ Gender: M / F
Address________________________ City______________
State______ Zip__________ Phone (____)__________ Patient Primary Language______________
Occupation______________ Employer______________ Work Phone______________
Address______________ City______________ State________ Zip__________
Subscriber Name______________ Health Plan______________
Subscriber ID #______________ Group #______________ Spouse Name______________
Spouse Employer______________ City______________ State________ Zip__________
Primary Care Physician Name______________ PCP Phone______________

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain
☐ Other______________

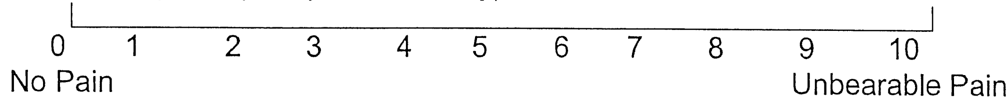


Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began______________

How Problem Began

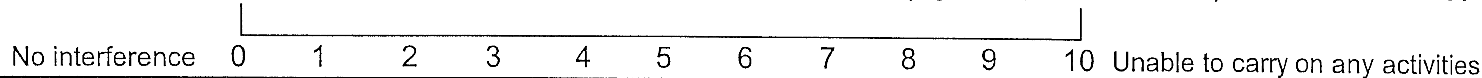
Current complaint (how you feel today):



0 1 2 3 4 5 6 7 8 9 10
No Pain — Unbearable Pain

How often are your symptoms present? ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100%

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?



No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken______________ **What areas were taken?**______________

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)______________
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)______________
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain)______________
☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks______________
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries______________
☐ Tobacco Use - Type______________
Frequency______________/Day
☐ Medications______________

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature______________ **Date**______________

Cervical Spine – Bournemouth Questionnaire

Name ____ Date ________________ Age______

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

1. Over the past week, on average, how would you rate your Neck 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 Neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?
   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 Neck 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 Neck 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 Neck pain on your own?
   Completely control it — No control whatsoever
   0 1 2 3 4 5 6 7 8 9 10

____

Signature

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.

Manatee Wellness & Chiropractic Centers

8792 East S.R. 70, Suite 101, Bradenton, FL 34202
Phone (941) 756-4362 Fax (941) 755- 4652

8405 US-301, Suite 104, Parrish, FL 34219
Phone (941) 803-4474 Fax (941) 755-4652

INFORMED CONSENT

I, ____________________, hereby request and consent to the performance of procedures, which may include, but is not limited to, spinal and extremity manipulation, massage, electrical muscular stimulation, ultrasound, and/or therapeutic modalities by either Dr. Amanda Mitchell D.C., Dr. Justin Mitchell D.C., and/or other licensed therapists or doctors who, now or in the future, treat me while employed by or associated with Manatee Wellness & Chiropractic Centers. I have had an opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and/or other procedures.

I understand and am informed that in the practice of chiropractic there are some risks to treatments including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name:____ Date:________________

Signature of Patient:____

Signature of Representative (if minor):________________________________

Relationship to Patient:____

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ACUPUNCTURE CONSENT

"Acupuncture" means the stimulation of a certain point or points near the surface of the body by the insertion of special needles. The purpose of acupuncture is to prevent or modify the perception of pain and is thus a form of pain control. In addition, through the normalization of physiological functions, it may also serve in the treatment of certain diseases or dysfunctions of the body. Acupuncture includes the techniques of electro-acupuncture (the therapeutic use of weak electric currents at acupuncture points), mechanical stimulation (stimulation of an acupuncture point or points on or near the surface of the body by means of apparatus or instrument), and moxibustion (the therapeutic use of thermal stimulus at acupuncture points by burning Artemisia alone or Artemisia formulations).

The potential risks: slight pain or discomfort at the site of needle insertion, infection (rare), bruises, weakness, fainting, nausea, and aggravation of problematic systems existing prior to acupuncture treatment.
The potential benefits: acupuncture may allow for the painless relief of one's symptoms without the need for drugs, and improve balance of bodily energies leading to the prevention of illness, or the elimination of the presenting problem.
Use of Disposable Needles: To reduce the possibility of infection from acupuncture, all needles are pre-sterilized, one-time-use needles made of surgical stainless steel needles. After each treatment they are disposed of as medical waste, needles are never reused. Additionally, Dr. Mitchell has had training in and follows the procedures of Clean Needle Technique and Universal Precautions.

I understand that Dr. Mitchell has recommended acupuncture treatment for me in the capacity of a pain mediator to reduce my symptoms. No cure or promises regarding my reaction to the treatment have been made or implied. I request and consent to the performance of the acupuncture procedure. I understand that I am free to withdraw my consent and that I may stop treatment or any procedure at any time. I understand that my signature in this form indicates that I have read and understand the preceding information regarding my treatment. I understand that if I have any questions about this information, I should ask my doctor. I, hereby release Dr. Mitchell and Manatee Wellness & Chiropractic Centers from any and all liability that may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care.

"With this knowledge, I voluntarily consent to the above procedures."

Patient Name:________________________________ Date:______________

Signature of Patient:____

Signature of Representative (if minor):____________________________

Relationship to Patient:____

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ASSIGNMENT OF BENEFITS

I, ______________________________, hereby authorize ______________________________
(name of insured) (name of insurance company)
to pay to and mail directly to Manatee Wellness & Chiropractic Centers the medical benefits otherwise payable to me for their services, but not to exceed the charges of those services. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I hereby irrevocably assign to Manatee Wellness & Chiropractic Centers the benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any services and charges provided by Manatee Wellness & Chiropractic Centers.

Patient Name:____ Date:__________________

Signature of Patient:____

Signature of Representative (if minor):____

Relationship to Patient:____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________, acknowledge that I was provided a copy of Manatee Wellness & Chiropractic Centers Notice of Privacy Practices, for which I have read, understood, and agree to the terms of the Privacy Practices.

Patient Name:____ Date:__________________

Signature of Patient:____

Signature of Representative (if minor):____

Relationship to Patient:____

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:
Social Security Number:
Birthdate:

I hereby authorize the Person/Organization providing the information to release medical information about me to Manatee Wellness & Chiropractic Centers.

Dates Of Service Needed: From:______________________ To: ______________________

Person/Organization Providing The Information	**Person/Organization Receiving The Information**
Name:	**Name:** Manatee Wellness & Chiropractic Centers
Address:	**Address:** 8792 East State Road 70, Suite 101 Bradenton, FL 34202-3705
Phone:	**Phone:** 941-756-4362
Fax:	**Fax:** 941-755-4652

Specific Description of Information Needed:

___X-Ray Reports ___MRI Reports ___CT Reports
___EMG Reports ___Progress Notes ___All Records

- I am aware that such records may contain information related to mental health, substance abuse (both alcohol and drug), and sexually transmissible diseases (including test results related to HIV/AIDS), and I specifically authorize the release of such information pursuant to this authorization.
- I understand that I may revoke the authorization at any time in writing. I further understand that any such revocation will not apply to any information already released under this Authorization. I understand that I am under no obligation to sign this Authorization, and that my ability to obtain treatment from Manatee Wellness & Chiropractic Centers will not depend in any way on whether I sign this authorization.
- I understand that I have a right to request a copy of this Authorization.

By signing below, I authorize the release of my medical information as described above.

Patient Signature:____ Date:________________

Representative Signature (if minor):_________________________ Date:________________

Relationship to Patient:____

American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
Fax: 877.248.2746

MEMBER BILLING ACKNOWLEDGMENT
For Medicare Advantage Member

For questions, please call ASH at 800.972.4226

IMPORTANT NOTICE: You may have additional coverage options for these services through your Medicare Advantage plan. If you have not received an Integrated Denial Notice from ASH or your Medicare Advantage plan, we recommend that you contact your health plan to inquire regarding coverage for these services prior to signing this form.

I,________________________ (Name of Patient/Member/Subscriber), a member being treated by Dr. Mitchell (Practitioner Name), do hereby acknowledge that a certain portion of my care will not be covered by my Medicare Advantage plan with ________________________ (Name of Health Plan).

I understand and agree to be responsible to self-pay for the following services:

LIST OF SERVICES TO BE PAID FOR BY MEMBER:

Date	Procedure	Charge
	NP Exam / Re-Exam	$ 75.00 / 45.00
	Massage x2 units	$ 45.00
	Acupuncture	$ 60.00
	Traction	$ 40.00
	Electric Stem / Ultrasound	$ 20.00

Separately list each date of service on which non-covered services will be rendered and have the member initial the charge. Please attach additional Member Billing Acknowledgment for Medicare Advantage Member form(s) for additional services.

This form is only to be used if an ASH member desires to self-pay for non-covered services. Non-covered services include services such as supplements that are not covered by the member's health plan. Non-covered services may also include services determined by ASH to be maintenance-type services.

The ASH Contracted Practitioner may not bill the member during the course of an ASH approved treatment program unless there is a copayment, deductible, coinsurance, or the member is receiving non-covered services.

The ASH Contracted Practitioner may not bill the member for the difference between what the ASH Contracted Practitioner bills and what the ASH Contracted Practitioner agreed contractually to accept as payment for services. This difference represents an amount the ASH Contracted Practitioner agreed contractually to waive.

This agreement may not be used as a "blanket" or "retroactive" agreement to bill members for any services not reimbursed by ASH. Such use will render this agreement "void" and non-binding on the member. This agreement may only be used to allow the member to agree to "self pay" for specific services <u>in advance</u>.

I acknowledge that I have received my Integrated Denial Notice explaining my denial rights, reviewed my coverage options, and have been told in advance of treatment what portion of my care I will have to pay for,

and agree to make financial arrangements with my practitioner, Dr. Mitchell (Practitioner Name), to pay for these services myself.

Dated at Bradenton (city), FL (state) this _______ (date) day of ____________ (month), 20_____ (year).

Member Signature
(Guardian must sign for all members 17 years or younger)

Member Health Plan ID#

[signature]
Practitioner Signature

Date

MbrBillingAckMA070115.docx