MEDICARE **ADULT**

Name: _____
Last First Middle

Male ___ Female ____ Date of Birth _____ Age _____

Marital Statues: Married Single Divorced Widowed Separated

Social Security #: _____-____-_____ Email: _____

Address: _____
Street City State Zip Code

Mailing Address: _____
Street City State Zip Code

Home #:_____ Work #:_____ Cell #:_____
Is it OK for Keith Clinic to send you text messages and/or voicemails? **Yes** **No**

Occupation: _____ Employer: _____

Employer Address: _____ Phone #_____

Name of spouse:_____ Date of Birth:_____SS#:_____

Emergency Contact: _____ Phone #: _____

How did you hear about our office? _____

Have you had other chiropractic care? _____ Reason _____

AUTHORIZATION FOR RELEASE OF INFORMATION AND PAYMENT OF MEDICAL BENEFITS

"I understand that I am responsible for all charges incurred by me WETHER OR NOT the insurance company pays. I herby assign all medical payments to Keith Clinic of Chiropractic; if there is any over payment it will be promptly refunded to me by Keith Clinic of Chiropractic. I authorize the release of any medical information needed to process my insurance claims. I agree to pay any/all collection cost, court cost and attorney's fees in addition to my chiropractic charges. Further more, I give Keith Clinic of Chiropractic Power of attorney to endorse checks made out to me, to be credited to my account. I understand that I am subject to a credit check before having any credit extended to me."

_____ _____
Patient Signature **Date**

NOTICE OF MEDICAL COVERAGE FOR CHIROPRACTIC CARE

Your Medicare Coverage of chiropractic care is limited. It does not pay for all services. It will only pay for your chiropractic adjustment (manipulative treatment) when it meets Medicare's specific rules. There are three categories of Medicare services:

1) Non-Covered 2) Always Covered 3) Perhaps Covered

Non-Covered Services:

According to existing Medicare Law, most of the services in our office are NON-COVERED. Hopefully, the U.S. Congress will change that someday and treat Doctors of Chiropractic like other doctors. Until then, here is a summary:

Example of Non-Covered Services

All Services Other that Chiropractic Adjustments:

- **O** Office Visits – to evaluate and manage, re-evaluate, advice, or give counsel regarding your health.
- **O** Physiotherapy – such as massage, traction, electrical Stimulation, neuromuscular re-education, etc.
- **O** X-rays Laboratory, Supplies, Vitamins, etc.

Various Chiropractic Adjustments or Treatments:

- **O** Non-spinal manipulation to the shoulder, arm, leg, etc.
- **O** Maintenance Care – you are stable and not making any more improvement.
- **O** Wellness Care – to promote better health.

Always Covered Services:

A Medicare Covered service is for when you are injured or when you are in pain due to a bad spinal condition. Medicare pays for your rehabilitation as long as you are improving. This phase of care is call "active treatment". It will be shown on your Medicare claim from and payment reports with your service code. For example "98940 – AT".

Perhaps Covered Services:

Your Chiropractic Adjustment must be clinically needed to correct a problem of the spine according to the Medicare Rules. If Medicare determines that your condition is not "Medial Necessary" they will not pay. When we know or believe that your chiropractic adjustment is no longer covered, we will discuss this matter with you. We will also give you a Medicare form known as the "Advance Beneficiary Notice" (ABN) which will show your financial obligation for continued care.

MY FINANCIAL RESPONSIBILITY

I have received the above Medicare information. I understand that I am personally financially responsible for all services not covered by Medicare. I am also responsible for applicable annual deductibles or copayments.

X_____ _____
Signature of Patient or Person acting on Patient's behalf Date

MY AUTHORIZATION

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

X_____ _____
Signature of Patient or Person acting on Patient's behalf Date

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to a payer, your health information on this form may be shared with the payer. Your health information which the payer sees will Be kept confidential by the payer.

Please describe the reason you are seeking treatment: _____

1. **How would you describe the pain?**
   - ◆Sharp ◆ Tingling
   - ◆Dull ◆ Numbness
   - ◆Stabbing ◆ Aching
   - ◆Burning ◆ Pinch
2. **Where does the pain radiate?**
   - ◆Head ◆ Hip
   - ◆Arm ◆ Groin
   - ◆Hand ◆ Thigh
   - ◆Shoulder ◆ Leg
   - ◆Chest ◆ Foot
3. **How did condition/injury happen?**
   - ◆Sudden
   - ◆Gradual
   - ◆Don't Know
   - ◆Describe_____
     _____
4. **When did you notice it?** _____
   _____
5. **When did it get worse?** _____
   _____
6. **Describe the intensity 0 to 10** (10 being the worse) 0 1 2 3 4 5 6 7 8 9 10
7. **How many hours a day do you experience the pain?** _____
8. **How long does the pain last?**_____ hours
9. **The pain lasts until I (describe)** _____
   _____
10. **In the morning it is?**
    - ◆Better ◆Same
    - ◆Worse ◆Does it keep you awake ____
    - ◆Are you awaken with Movement
11. **What makes the pain worse?**
    - ◆Movement ◆Getting out of _____
    - ◆Bending ◆Prolonged(Standing)(Sitting)
    - ◆Lifting ◆Coughing
    - ◆Sitting ◆Sneezing
    - ◆Nothing ◆Putting on shoes/pants/shirt
    - ◆Brushing teeth ◆Shaving
    - ◆Other _____
12. **What makes the pain better?**
    - ◆Rest ◆Sitting
    - ◆Walking ◆Nothing
    - ◆Ice/Heat ◆Stretching
    - ◆Laying ◆Self Massage
    - ◆Medication ◆Other_____
13. **The previous treatment was…**
    - ◆Chiropractic ◆Medical
    - ◆Other treatment ◆Successful
    - ◆Not Successful

    Describe Treatment:
    - ◆Spinal Manipulation
    - ◆Therapy ◆X-rays
    - ◆Medication ◆Surgery
    - ◆Other _____
14. **Have you ever had a:**
    - ◆Fall ◆Auto Accident
    - ◆Surgery ◆Broken Bone
    - ◆Serious Illness
    - ◆Hospitalization
15. **Do you feel the previous trauma, serious illness, or hospitalization affects the reason you are here today?**
    YES NO
16. **Describe treatment and list related condition:** _____
17. **Are you currently under treatment for any condition** _____ **describe** _____
18. **If so, do you feel your current condition affects the reason you are here today? YES NO**
19. **List current medications and related condition** _____
    _____

20. Have you received previous Chiropractic Treatment? YES NO
Describe _____

21. Do you Smoke? YES NO
how many pks a day? _____

22. Drink Alcohol? YES NO
how many drinks a day? _____

23. Recreational Drugs YES NO

24. Have you ever suffered from:
- Cancer
- Diabetes
- Heart Problems
- Kidney
- Liver
- Stomach Problems _____
- Other_____

25. Mother's Age _____

Mother's Condition:
- Good Health
- Heart
- Diabetes
- Cancer
- Other_____
- Deceased-Caused _____

26. Father's Age _____

Father's Condition:
- Good Health
- Heart
- Diabetes
- Cancer
- Other_____
- Deceased-Caused _____

27. List ages and sex of all brothers and sisters
_____
_____
_____

28. All brothers and sister are in good health?
-
If no describe _____
_____

29. List the age and sex of all Children_____
_____
_____

30. All children are in good health?
YES NO
If no describe _____
_____

31. Describe exercise and hobbies
- Walk
- Run
- Golf
- Tennis
- Bike
- Read
- Other/Describe _____
_____

32. Does your current condition affect your exercise, hobby or work activity?
- YES
- NO
- Describe: _____
_____
_____
_____

MEDICARE CONTRAINDICATIONS

Do you suffer from any of the following?

Yes	No	Osteoporosis or Osteopenia
Yes	No	Tumor of the Spine
Yes	No	Do you take anicoagulant therapy/blood thinners (warfarin, coumadin)
Yes	No	ALS (Lou Gehrig's Disease)
Yes	No	Leukemia
Yes	No	Do you have foot drop, progressively worsening arm or leg pain or weakness
Yes	No	Rheumatoid Arthritis
Yes	No	Ankylosing spondylitis
Yes	No	Recent fracture of the spine or surgery to repair spinal fractures
Yes	No	Cancer of the spine
Yes	No	Stroke
Yes	No	Infection of the spine
Yes	No	Weakness of the legs, inability to control bowel or bladder
Yes	No	Aneurysm
Yes	No	Blurred vision, TIA's, slurred speech, numbness of face, arm or leg

History taken by:_____

Reviewed with patient:_____

Contraindications noted: Yes No

Patient Signature:_____

Date:_____

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Neck

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Back

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

YOUR RIGHTS

Get an electronic or paper copy of your medical record

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

ONLY if you pay for a service or health care item out-of-pocket, in full, at the time of service, can we comply with your request not to share that information for the purpose of payment or our operations with your health insurer. (i.e. - comply with your request not to file your claims to your insurance company). Otherwise, we will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- **Share information with your family, close friends, or others involved in your care**
- **Share information in a disaster relief situation**
- **Contact you for fundraising efforts**

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- **Marketing purposes**
- **Sale of your information**

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

- **Treat you**
  We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

- **Run our organization**
  We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.
- **Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues

We can share health information about you for certain situations such as preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; and, preventing or reducing a serious threat to anyone's health or safety.

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you for workers' compensation claims, for law enforcement purposes, or with a law enforcement official. We can also use or share health information about you with health oversight agencies for activities authorized by law for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective September 23, 2013

Patients Name (printed) : _____ **Date:** _____

Patient Signature of Acceptance: _____ **Date:** _____

Witness: _____

Informed Consent

Disclosure & Consent
Chiropractic adjustments and Care

TO THE PATIENT: You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risk and hazards involved. This disclosure is not meant to scare or alarm you: it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I herby request and consent to performance of chiropractic adjustment and other chiropractic procedures, including carious modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other Licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below my diagnosis the nature and purpose of chiropractic adjustments and other procedures and alternatives. I understand and I am informed that in the practice of chiropractic there are some risk to exam and treatment including, but not limited to fractures, disc injuries, strikes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risk 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 on the facts the known, is in my best interest. I further acknowledge that no guarantees or assurance have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent from to cove treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient:

_____
Print name

_____
Signature of Patient

_____
Date Signed

_____
Doctor Signature of Keith Clinic of Chiropractic P.A.

To be completed by the patient's representative:

_____
Print Name of Patient

_____
Print Name of Representative

_____
Signature of Representative

_____
Date Signed

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize the use and disclose of my individually identifiable health information as described below. I understand that this authorization is voluntary.

Patient Name:_____

Patient address:_____

SS#:_____ Date of Birth:_____

Person/Organization Providing Information:_____

Address:_____

Person/Organization Receiving Information:_____

Address:_____

For the purpose of _____

Specific description of information covering health care from_____ to _____

- Complete health records
- Lab and x-ray reports
- Other (Please specify)_____

Unless otherwise revoked, this authorization will expire on the following date, event or condition_____. If fail to specify an expiration date, event or condition, this authorization will expire in six months.
I may revoke this authorization at any time in writing to the concerned parties. The revocation will not be effective to the extent that others or we have acted in reliance upon this authorization may be subject to re-disclosure by the recipient and no longer be protected by this rule.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Signature of Witness