CONFIDENTIAL DATA

NAME:_____
(FIRST) (MI) (LAST)

CALLED NAME (NICKNAME) _____

ADDRESS_____ APT_____

CITY_____ STATE _____ ZIP_____

PRIMARY PHONE_____ (CIRCLE ONE: CELL HOME OTHER_____)

ALT. PHONE _____ (CIRCLE ONE: CELL HOME OTHER_____)

EMAIL _____

MARITAL STATUS: S M W D

DATE OF BIRTH _____

HOW DID YOU LEARN ABOUT THIS CLINIC? _____

EMERGENCY CONTACT: _____
(NAME) (PHONE) (RELATIONSHIP)

INSURANCE:

PRIMARY INSURANCE COMPANY NAME _____

SUBSCRIBER NAME: _____ DATE OF BIRTH _____

RELATIONSHIP TO PATIENT: _____ EMPLOYER: _____

SECONDARY INSURANCE NAME (IF APPLICABLE) _____

SUBSCRIBER NAME: _____ DATE OF BIRTH _____

RELATIONSHIP TO PATIENT: _____ EMPLOYER: _____

Informed Consent

We encourage and support a **shared decision-making process** between us regarding your health needs. This information is provided so that you can make an informed decision to undergo such care, and can knowledgably give or withhold your consent.

A **vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra is misaligned and/or does not move properly, causing interference and/or irritation to the nervous system. The primary goal of chiropractic care is the removal/reduction of nerve interference caused by subluxations through adjustments. The **chiropractic adjustment** is the application of a precise movement and/or force into the spine (or other joint) in order to reduce or correct the subluxation(s). There are different methods of delivery, but adjustments are typically performed by hand. Other methods and procedures may be included in the treatment protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

RISKS OF CHIROPRACTIC CARE: All medical care has associated risks. Chiropractic is no different. Risks include soreness, muscle and/or joint pain, musculoskeletal sprain/strain, and fracture. The most serious risk associated with chiropractic care is stroke or cardiovascular incident. The risk is minimal when compared to other medical treatments. The risk is calculated to be one in two million adjustments.

We are not able to promise complete recovery. We will use our best efforts and most effective therapies to provide you the best possible results. If your symptoms do not respond to treatment within a reasonable amount of time, we will suggest other avenues of therapy or refer you to an appropriate doctor. Examples include primary care physician, orthopedic surgeon, neurologist, physiatrist, physical therapist, acupuncturist, or massage therapist.

I have been informed of the nature and purpose of chiropractic care, the possible outcomes of care and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences, and probable effectiveness of each. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE THE CHIROPRACTORS OF EMERY CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

_____

Patient Name and Date of Birth (**please print**)

_____ _____

Patient (or legal guardian) **signature** Date

HIPAA Compliance Patient Consent Form

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) gives you the right to privacy in regard to your protected healthcare information. Emery Chiropractic Clinic has a 30 page notice that explains our privacy policies and your rights. You may request to see it at any time. You ascertain that by your signature that you have reviewed and/or declined to review our notice before signing this consent.

By signing this form, I understand that:

- It gives consent to the clinic's policies of use and disclosure of the patient's protected healthcare information and potentially anonymous usage in a publication.
- The patient has the right to review their records.
- The patient has the right to restrict the use of the information. However, HIPAA still allows for the use of the information for treatment, payment, or healthcare operations.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. Such a revocation will not be retroactive.

I give my permission to Emery Chiropractic, PC to:

- Send text alert reminders for my appointments. YES NO
- Leave a *detailed* message. YES NO
- Discuss my medical condition and/or account balance with (specified) others. YES NO

If YES, please list the people we are allowed to share with, and any restrictions on what may be discussed:

_____

_____

PRINT: Patient Name & Date of Birth _____

AND

SIGN: Patient (or Legal Representative) Signature: _____ Date _____

If you are patient's representative, describe relation/authority to act on their behalf (ex: parent, legal guardian, PoA)

_____

FINANCIAL POLICY:

- The patient portion of the balance (such as copay, deductible prepay, or full balance for those without insurance) is due at the time of service unless arrangements have been made in advance. We collect *an estimate* each visit for deductibles. Remaining balances (deductibles, co-insurance, non-covered/denials) are due after claim processes.

- All fees are charged to the patient's account. If a third party, such as an insurance company, is expected to pay the fees, it is the patient's responsibility to provide accurate, current information and alert staff of changes. While we verify benefits as a **courtesy**, it is the patient's responsibility to be aware of the benefits & limitations of their plan.

- Benefits quoted by insurance is not a guarantee of coverage. Insurance companies reserve the right to make the final determination of coverage at the time of claims processing. Please understand that any differences between what was quoted and how it processes are beyond the clinic's control.

- If your insurance policy requires a **referral** from another doctor, or **preauthorization** from insurance, you MUST obtain the referral before your appointment. It is **your responsibility** to know if one is required and secure it.

- **The fees for service are ultimately the responsibility of the patient, *regardless of insurance coverage***. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim for any reason, reverses payment at a later date, or you elect to continue treatment past your benefit limit, you will be responsible for your account balance in full. If you request that we submit services we don't believe will be covered, understand that you take the financial risk and will owe the balance if they don't pay for any reason.

- **HSA, HRA, and FSA accounts**: If you have one of these funds, please be aware that disputes with your fund are separate from your account with us. Your bill is still due, even if they aren't releasing funds. We are happy to provide receipts for you to submit for reimbursement, but your account will become overdue if you stall payment while appealing their denial. We can also wait and run your HSA card for the exact amount if kept on file (see below).

- We do our best to work with patient's financial situations. Our primary concern is that you are able to continue care as long as you need it. If you can't pay in full, we are happy to work out monthly payments. Accounts become delinquent if no payment is received over 90 days from the first billing cycle and may be turned over to collections.

I have read the above policy regarding my financial responsibility to Emery Chiropractic for providing treatment. I certify that any insurance information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Emery Chiropractic. I understand the financial responsibilities laid out in this form, and I agree to abide by them.

1. Yes / No I want more information regarding online bill pay.

2. We can securely save your credit/debit card on file. (HSA card - please tell us. We can charge deduct/coinsurance when claim processes) **CHECK ONE**:

_____ Save my card. I give permission to charge the card for balance due if I am not present. Receipt available upon request.

_____ Save my card. I do not give permission to use my card if I am not present. I understand that if my account is delinquent, my card still will be charged to avoid possible collections. I understand that attempts will be made by staff to contact me first.

_____ I do not want to save my card on file.

Patient Name _____ (PLEASE PRINT) Date: _____

SIGN: _____ Relation to Patient: _____

I, _____, am the **guarantor** for payments on this patient's account. This remains active until I cancel in writing. Please send bills to the following address: _____

OSWESTRY LOW BACK PAIN INDEX

No pain	0	1	2	3	4	5	6	7	8	9	10	*Unbearable pain*

Please rate the severity of your pain by marking a number below:
Please read: Please answer every question, and check only the **one** statement in each section that applies to you. While you may consider that two of the statements in any one section relate to you, please check just the **one** which most closely describes your situation.

Section 1 – Pain Intensity

- O A. The pain comes and goes and is very mild.
- O B. The pain is mild and does not vary much.
- O C. The pain comes and goes and is moderate.
- O D. The pain is moderate and does not vary much.
- O E. The pain comes and goes and is severe.
- O F. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)

- O A. I would not have to change my way of washing or dressing in order to avoid pain.
- O B. I do not normally change my way of washing or dressing even though it causes some pain.
- O C. Washing and dressing increase the pain but I manage not to change my way of doing it.
- O D. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- O E. Because of the pain I am unable to do some washing and dressing without help.
- O F. Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting

- O A. I can lift heavy weights without extra pain.
- O B. I can lift heavy weights but it gives extra pain.
- O C. Pain prevents me lifting heavy weights off the floor.
- O D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- O E. Pain prevents my lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- O F. I can only lift very light weights at most.

Section 4 – Walking

- O A. Pain does not prevent me from walking any distances.
- O B. Pain prevents me from walking more than one mile.
- O C. Pain prevents me from walking more than 1/2 mile.
- O D. Pain prevents me from walking more than 1/4 mile.
- O E. I can only walk while using a cane or crutches.
- O F. I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- O A. I can sit in any chair as long as I like without pain.
- O B. I can sit in my favorite chair as long as I like.
- O C. Pain prevents me from sitting more than 1 hour.
- O D. Pain prevents me from sitting more than ½ hour.
- O E. Pain prevents me from sitting more than 10 minutes.
- O F. Pain prevents me from sitting at all.

Section 6 – Standing

- O A. I can stand as long as I want without pain.
- O B. I have some pain on standing but it does not increase with time.
- O C. I cannot stand for longer than 1 hour without increasing pain.
- O D. I cannot stand for longer than ½ hour without increasing pain.
- O E. I cannot stand for longer than 10 minutes without increasing pain.
- O F. I avoid standing because it increases pain immediately.

Section 7 – Sleeping

- O A. I get no pain in bed.
- O B. I get pain in bed but does not prevent me from sleeping well.
- O C. Because of pain my normal night's sleep is reduced by less than one-quarter.
- O D. Because of pain my normal night's sleep is reduced by less than one-half.
- O E. Because of pain my normal night's sleep is reduced by less than three-quarters.
- O F. Pain prevents me from sleeping at all.

Section 8 – Social Life

- O A. My social life is normal and gives me no pain.
- O B. My social life is normal but it increases the degree of pain.
- O C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
- O D. Pain has restricted my social life and I do not go out very often.
- O E. Pain has restricted my social life to my home.
- O F. I have hardly any social life because of the pain.

Section 9 – Traveling

- O A. I get no pain while traveling.
- O B. I get some pain when traveling but none of my usual forms of travel make it any worse.
- O C. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
- O D. I get extra pain while traveling which compels me to seek alternative forms of travel.
- O E. Pain restricts me to short necessary journeys under ½ hour.
- O F. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain

- O A. My pain is rapidly getting better.
- O B. My pain fluctuates but is definitely getting better
- O C. My pain seems to be getting better but improvement is slow.
- O D. My pain is neither getting better or worse.
- O E. My pain is gradually worsening.
- O F. My pain is rapidly worsening.

Print name _____ Signature _____ Date _____

NECK DISABILITY INDEX

Please rate the severity of your pain by circling a number below:

No pain	0	1	2	3	4	5	6	7	8	9	10	*Unbearable pain*

Please read: Please answer every question, and mark only the **one** statement in each section that applies to you. While you may consider that two of the statements in any one section relate to you, please check just the **one** which most closely describes your situation.

Section 1 – Pain Intensity

- ○ A. I have no pain at the moment.
- ○ B. The pain is very mild at the moment.
- ○ C. The pain is moderate at the moment.
- ○ D. The pain is fairly severe at the moment.
- ○ E. The pain is very severe at the moment.
- ○ F. The pain is the worst imaginable at the moment.

Section 2 – Personal Care (Washing, Dressing, etc.)

- ○ A. I can look after myself without causing extra pain.
- ○ B. I can look after myself normally but it causes extra pain.
- ○ C. It is painful to look after myself and I am slow and careful.
- ○ D. I need some help, but manage most of my personal care.
- ○ E. I need help every day in most aspects of self-care.
- ○ F. I do not get dressed; I wash with difficulty and stay in bed.

Section 3 – Lifting

- ○ A. I can lift heavy weights without extra pain.
- ○ B. I can lift heavy weights but it gives extra pain.
- ○ C. Pain prevents me lifting heavy weights off the floor, but I can if they are conveniently positioned, e.g. on the table.
- ○ D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ○ E. I can lift very light weights.
- ○ F. I cannot lift or carry anything at all.

Section 4 – Reading

- ○ A. I can read as much as I want to with no pain in my neck.
- ○ B. I can read as much as I want to with slight pain in my neck.
- ○ C. I can read as much as I want to with moderate pain in my neck.
- ○ D. I cannot read as much as I want to because of moderate pain in my neck.
- ○ E. I cannot read as much as I want to because of severe pain in my neck.
- ○ F. I cannot read at all.

Section 5 – Headache

- ○ A. I have no headache at all.
- ○ B. I have slight headaches which come infrequently.
- ○ C. I have moderate headaches which come infrequently.
- ○ D. I have moderate headaches which come frequently.
- ○ E. I have severe headaches which come infrequently.
- ○ F. I have headaches most of the time.

Section 6 – Concentration

- ○ A. I can concentrate fully when I want to with no difficulty.
- ○ B. I can concentrate fully when I want to with slight difficulty.
- ○ C. I have a fair degree of difficulty in concentrating when I want to.
- ○ D. I have a lot of difficulty in concentrating when I want to.
- ○ E. I have a great deal of difficulty in concentrating when I want to.
- ○ F. I cannot concentrate at all.

Section 7 – Work

- ○ A. I can do as much work as I want to.
- ○ B. I can only do my usual work, but no more.
- ○ C. I can do most of my usual work, but no more.
- ○ D. I cannot do my usual work.
- ○ E. I can hardly do any work at all.
- ○ F. I cannot do any work at all.

Section 8 – Driving

- ○ A. I can drive my car without neck pain.
- ○ B. I can drive my car as long as I want with slight pain in my neck.
- ○ C. I can drive my car as long as I want with moderate pain in my neck.
- ○ D. I cannot drive my car as long as I want because of moderate pan in my neck.
- ○ E. I can hardly drive my car at all because of severe pain in my neck.
- ○ F. I cannot drive my car at all.

Section 9 – Sleeping

- ○ A. I have no trouble sleeping.
- ○ B. My sleep is slightly disturbed (less than 1 hour sleepless).
- ○ C. My sleep is mildly disturbed (1-2 hours sleepless).
- ○ D. My sleep is moderately disturbed (2-3 hours sleepless).
- ○ E. My sleep is greatly disturbed (3-5 hours sleepless).
- ○ F. My sleep is completely disturbed (5-7 hours sleepless).

Section 10 – Recreation

- ○ A. I am able to engage in all recreational activities with no pain in my neck.
- ○ B. I am able to engage in all recreational activities with some pain in my neck.
- ○ C. I am able to engage in most, but not all recreational activities because of pain in my neck.
- ○ D. I am able to engage in a few of my recreational activities because of pain in my neck.
- ○ E. I can hardly do recreational activities because of pain in my neck.
- ○ F. I cannot do any recreational activities at all.

Print name _____ Signature _____ Date _____

Patient Health Questionnaire

ACN Group, Inc. Form PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

1. When did your symptoms start: _____ **Describe your symptoms and how they began:**

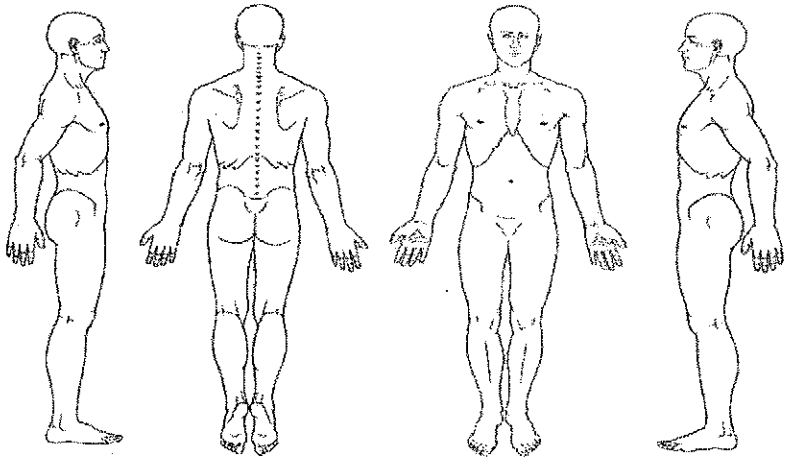
_____

_____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. How bad are your symptoms at their:

	None										Unbearable
a. worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints		*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*		*Severe, no activity possible*

7. What activities make your symptoms worse: _____

8. What activities make your symptoms better: _____

9. Who have you seen for your symptoms?

① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. When and what treatment? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

10. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

11. What is your occupation?

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

12. What do you hope to get from your visit/treatment *(select all that apply):*

① Reduce symptoms
② Resume/increase activity
③ Explanation of condition/treatment
④ Learn how to take care of this on my own
⑤ How to prevent this from occurring again
⑥

Patient Signature _____ **Date** _____

Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] (Feet / Inches) Weight [ ][ ][ ] lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
○	○	Headaches	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Frequent Urination
○	○	Mid Back Pain	○	○	Stroke			
○	○	Low Back Pain	○	○	Angina	○	○	Smoking/Use Tobacco Products
						○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Stones			
○	○	Elbow/Upper Arm Pain	○	○	Kidney Disorders	○	○	Allergies
○	○	Wrist Pain	○	○	Bladder Infection	○	○	Depression
○	○	Hand Pain	○	○	Painful Urination	○	○	Systemic Lupus
			○	○	Loss of Bladder Control	○	○	Epilepsy
○	○	Hip/Upper Leg Pain	○	○	Prostate Problems	○	○	Dermatitis/Eczema/Rash
○	○	Knee/Lower Leg Pain				○	○	HIV/AIDS
○	○	Ankle/Foot Pain	○	○	Abnormal Weight Gain/Loss			
			○	○	Loss of Appetite	***Females Only***		
○	○	Jaw Pain	○	○	Abdominal Pain	○	○	Birth Control Pills
						○	○	Hormonal Replacement
○	○	Joint Swelling/Stiffness	○	○	Ulcer	○	○	Pregnancy
○	○	Arthritis	○	○	Hepatitis	○	○	
○	○	Rheumatoid Arthritis	○	○	Liver/Gall Bladder Disorder			
						Other Health Problems/Issues		
○	○	General Fatigue	○	○	Cancer	○	○	
○	○	Muscular Incoordination	○	○	Tumor	○	○	
○	○	Visual Disturbances				○	○	
○	○	Dizziness	○	○	Asthma			
			○	○	Chronic Sinusitis			

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ ***Date*** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ ***Date*** _____