RS&J | Restorative spine & joint

1767 S. Broadway
Santa Maria, CA 93454
(805)614-7820
(805) 614-7823

Patient Name: _____DOB: _____Date:_____

Ht: *Wt:* *Pulse:* *BP:* *RESP:* *TEMP:*

Chief Complaint:

What is the main reason for seeking treatment? _____

_____

_____

How long have you experienced your symptoms? _____

How bad are your symptoms at their worst? 1 2 3 4 5 6 7 8 9 10 (circle) - *10 being the worst*

How bad are your symptoms at their best? 1 2 3 4 5 6 7 8 9 10 (circle) - *10 being the worst*

What, if anything has made the problem worse?

❑Driving ❑walking ❑ working ❑bending ❑sports ❑sleeping ❑Other: _____

What, if anything, has made the problem better?

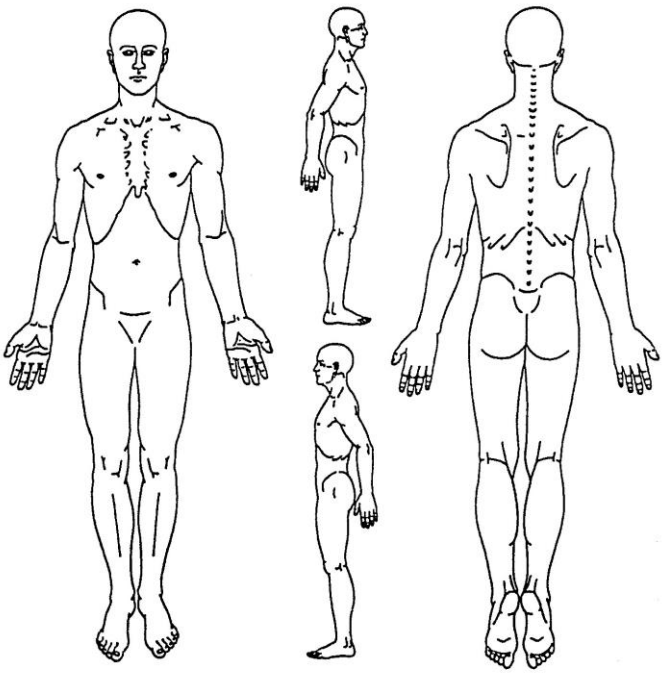
❑Rest ❑ ice ❑ heat ❑elevation ❑NSAIDS ❑pain meds ❑nothing

What have you tried?

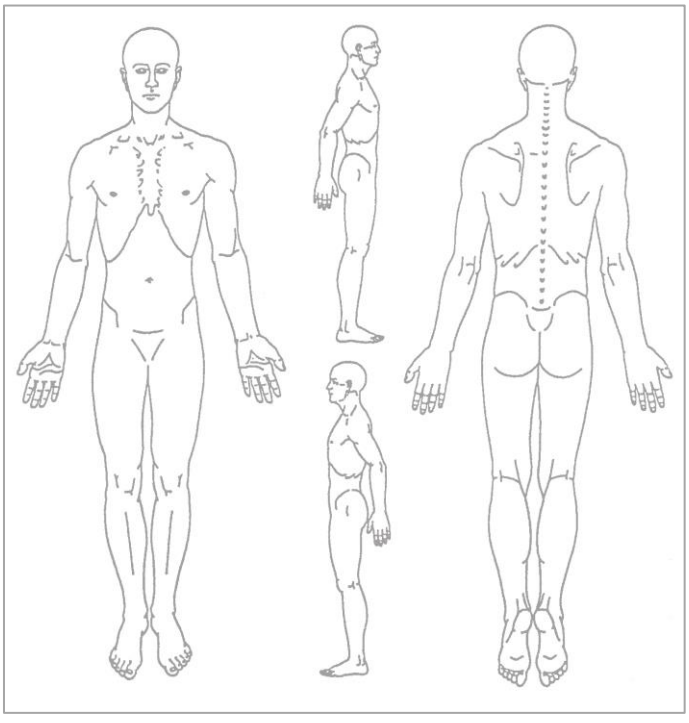
❑Chiropractic ❑ Physical Therapy ❑ Injections ❑Other: _____

What was the outcome? _____

Areas of complaint (please circle areas)



(provider use only)



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Patient Name: _____DOB: _____Date:_____

History of Present Injury/Illness:

❑ Neck Pain/Stiffness	❑ Pins/Needles in Arms	❑ Light Bothers Eyes
❑ Sudden Weight Loss	❑ Pins/Needles in Legs	❑ Loss of Taste
❑ Back Pain/Stiffness	❑ Depression	❑ Nausea
❑ Cold Feet	❑ Arm/Hand Pain	❑ Fatigue
❑ Nervousness	❑ Loss of Memory	❑ Chest Pain
❑ Leg/Knee Pain	❑ Sleeping Difficulties	❑ Tension
❑ Jaw Problems	❑ Fever	❑ Headaches
❑ Loss of Smell	❑ Cold Sweats	❑ Constipation
❑ Fainting	❑ Dizziness	❑ Allergies
❑ Stomach Problems	❑ Shortness of Breath	❑ Asthma
❑ Blurred Vision	❑ Night Pain	❑ Bowel/Bladder Changes

Medical History:

❑Hypertension	❑ High cholesterol	❑ Migraines	❑ Liver Disease	❑ Rheumatoid Arthritis
❑Heart Disease	❑ Herniated disc	❑ Cancer	❑ Kidney Disease	❑ Fibromyalgia
❑ Pinched nerve	❑ Pacemaker	❑ Ulcers	❑ Osteoporosis	❑ Thyroid problems
	❑ Stroke	❑ Arthritis	❑Diabetes	❑ Bleeding Disorders

Are you currently under drug and/or medical care? ❑ Yes ❑ No

Do you have any Allergies to Medications? _____

Who is your primary care Doctor? _____

List all medications: (Be sure to include dosage and frequency): _____

_____

Supplements (vitamins/herbs/minerals): _____

Surgeries and/ hospitalizations (type & date): _____

WOMEN ONLY: Date of LMP:_____ ***Any possibility of pregnancy: YES or NO***

Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents & siblings)

❑ Heart Disease_____ ❑ Diabetes_____ ❑ Cancer _____

❑ Arthritis_____ ❑ Other _____

Intake of following: Cigarettes _____ *packs/day* Alcohol _____*drinks/week* Caffeine ____ *cups/day*

Exercise frequency: ❑Never ❑Daily ❑ Weekly

Type of exercise: ❑Walks ❑Runs ❑Swims ❑Other: _____

Occupation:_____

Does work mostly involve : ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

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Patient Name: _____DOB: _____Date:_____

NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE

For any YES answer, please include details.

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment: _____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment: _____
3. Do your hands or arms fall asleep regularly? NO YES
   Comment: _____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment: _____
5. Do you suffer from a loss of handgrip strength? NO YES
   Comment: _____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment: _____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: _____
8. Do your legs or feet fall asleep regularly? NO YES
   Comment: _____
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
   Comment: _____
10. Do you suffer from cold hands or feet? NO YES
    Comment: _____
11. Do you suffer from seasonal or year round allergies? NO YES
    Comment: _____
12. Do you suffer from headaches? If yes, how often, how severe, what has been tried? NO YES
    Comment: _____
13. Do you/have you suffered from TMJ? What treatments have you tried?
    (bite guard, ice, massage, dental work, PT, Rx meds) NO YES
    Comment: _____
14. Any medicines previously tried for this complaint, dosage, duration and outcome. NO YES
    ☐Advil ☐Aleve ☐Tylenol ☐Steroids ☐ Other: _____
    Prescriptions for a period of ☐0-3mos, ☐3-6mos, ☐6-12 mos ☐12+mos
15. Have you had an MRI or X-rays? NO YES
    If yes: When? Who ordered it? What was it ordered for? What facility?_____
    _____
16. Have you used any splint or braces or other prescribed treatment by your doctor? NO YES
    If yes: When? What kind? Who ordered it? _____

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ADLS/IADLS	REQUIRES NO ASSISTANCE	SOME ASSISTANCE NEEDED	COMPLETE ASSISTANCE NEEDED	NOT APPLICABLE
BATHING				
DRESSING				
GROOMING				
ORAL CARE				
TOILETING				
TRANSFERRING				
WALKING				
CLIMBING STAIRS				
EATING				
SHOPPING				
COOKING				
MANAGING MEDICATIONS				
USES THE PHONE				
HOUSE WORK				
LAUNDRY				
DRIVING				
TOTALS				

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of Patient/ Parent or Guardian Date

Chiropractor Signature: _____ Date Reviewed: _____

Advanced Practice Provider Signature: _____Date Reviewed: _____

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Patient Name: _____DOB: _____Date:_____

SS #/SIN_____ Date of Birth_____ ☐Male ☐Female
Patient's Address _____City _____ State____ Zip_____
Cell phone_____ Alternate Phone _____
Email: _____
Employer Name: _____
Check appropriate Box**:** ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated
Spouse or Patient's Guardian name_____
Whom may we thank for referring you? _____
Person to contact in case of an emergency: _____Phone_____
In case of a medical emergency, if the patient is of school age 15+, it is ok to treat in my absence.

_____ _____
PARENT OR GUARDIAN SIGNATURE **DATE**

Responsible Party
Name of the person responsible for this account _____
Relationship to Patient _____Driver's License # _____
Date of Birth: _____ is the person currently a patient at our office? □ Yes □ No

Do you have any Medical insurance? □ Yes □ No if yes, complete the following:

Name of the insured_____
Relationship to patient_____Birthdate_____SS#/SIN_____
Insurance Company_____ Group #_____
Subscriber #_____Union or local # _____
Ins. Co. Address _____City _____ State _____ Zip_____

Consent to receive electronic communication via text and or email:
Signature: _____

RESTORATIVE SPINE & JOINT CONSENT TO TREAT

I hereby request and consent to the performance of examination, chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below.
I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.
I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:
Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.
Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.
Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.
I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.
I have read, or have had read to me, the above consent. I have also had an 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.

Signature of Patient or legal guardian: _____ Date: _____

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Patient Name: _____DOB: _____Date:_____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **RESTORATIVE SPINE & JOINT** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signature of Patient or legal guardian: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

As required by HIPPA privacy regulations, I hereby acknowledge that I have been presented and have read a current copy of Restorative Spine & Joint **NOTICE OF PRIVACY PRACTICES**.

As required by HIPPA privacy regulations Restorative Spine & Joint has explained the **NOTICE OF PRIVACY PRACTICES** to my satisfaction. As required by the HIPPA privacy regulations, I am aware that Restorative Spine & Joint has included a provision that reserves the right to change the terms of its notice and make the new notice provisions effective for all protected health information that it maintains. I understand that this office is not required to honor any changes of the **NOTICE OF PRIVACY PRACTICES.**

Signature of Patient or legal guardian: _____ Date: _____

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Patient Name: _____DOB: _____Date:_____

Financial Policy

Welcome to our office! Your health is our chief concern and we strive for excellence in chiropractic care. In order to make the handling of your financial obligations as smooth as possible, please read and sign the following policy. If you have any questions, our staff will be happy to assist you.

General Insurance Information

Please remember that all health and accident policies are arrangements between you and the company that writes the policy. All charges in this office are your personal responsibility and all fees are charged directly to you. As a courtesy to you, we will prepare necessary insurance claim forms to assist in collections from your insurance company. We will also bill insurance on your behalf and will expect payment from them within 60 days. Should the claim remain unpaid over 60 days for any reason, we will then personally bill you for the balance, net 30 days. Please note that this office will not enter into dispute with an insurance company over your claim.

Your coverage (PPO, HMO, EPO, HSA, etc)

This office is under contract with many insurance plans. Please present your insurance card to the front desk so that we may make a copy for your file. On your behalf, we will immediately begin verifying your estimated coverage. You will need to sign the Signature on File/Authorization form. Your financial obligation may consist of a co-payment and/or a deductible. The co-payment will be either a fixed amount or a percentage of the charges. Co-payments vary from plan to plan but generally range from $5.00 - $30.00 per visit. **PLEASE NOTE THAT YOU ARE RESPONSIBLE FOR PAYMENT OF ALL FEES FOR PROFESSIONAL SERVICES EVEN THOUGH YOU MAY HAVE INSURANCE COVERAGE-this means that should the insurer fail to pay sums due, you are responsible for the payment.**

Worker's Compensation

With authorization to treat from your employer, if you are hurt on the job your care is handled 100% through eligible worker's compensation benefits.

Personal Injury

This category also includes automobile accidents. If you have medical coverage (med-pay) on your auto insurance policy, we will bill them directly for prompt payment of your care. This coverage is in place to immediately handle your medical needs regardless of who is at fault. If you are not at fault, you will not be penalized by your insurance company as they will collect for reimbursement from the responsible party. If med-pay is not part of your coverage, we will set up monthly payment arrangements upon your request. Please remember, you are directly responsible for payment of your bill.

Medicare

We are happy to accept Medicare patients, and we accept Medicare assignment. You will receive our MEDICARE ADVANCECED BENEFICIARY NOTIFICATION. Please read and sign this form. We will be happy to answer any questions.

Personal Pay/Time of Service

Because of decreased administrative costs, we are able to extend a time of service (T.O.S.) discount to our patients who do not have or choose not to use their insurance. To receive this discount, services must be paid for at the time they were rendered. The discount will not apply if we must send a bill for payment. If you have any questions regarding this time of service discount, please speak to our office manager. **For Example:**

Typical adjustment	$65.00
Payment at time of service	-$12.00
Balance	$53.00

No Show Policy

It is important to our patients that we stay on schedule and make ourselves available to those patients in need with minimal or no wait time. To make this happen, we work hard to keep on schedule and many times have a waiting list for patients needing care. If you must cancel an appointment, we understand that things come up. A courtesy phone call is very important. A “no-show” takes an opportunity away from another patient who may be wanting to get in sooner. To that end, our office has implemented a “no-show” fee of **$40.00** which will be paid in full prior to the next scheduled visit.

•• ••

I HAVE READ AND UNDERSTAND MY RESPONSIBILITY CONCERNING PAYMENT/POLICIES IN THIS OFFICE. I agree to be responsible for payments of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account and the time of service discount will become void. If required, I also understand a check of my credit history may be made. I agree to pay all costs of collection, including attorney fees should legal action be necessary.

_____ _____ _____

Patient Name **Patient/ Guardian Signature** **Date**