ADVANCED CARE
CHIROPRACTIC AND WELLNESS CENTER

Patient Health History

Date:

Signature of Patient _____

Where or whom did you hear about Advanced Care? _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Nick Name**_____

Last Name_____ **Middle Name**_____ **Suffix** _____

Address 1 _____

Address 2 _____

City_____ **State**_____ **Zip Code** _____

Primary Phone_____ **Secondary Phone** _____

Mobile Phone _____

Home email_____ **Work Email** _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth **Age**_____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Your Insurance Company's Name: _____

Your Insurance Identification Number: _____

Your Insurance Group Number: _____

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑Samoan	❑ Guamanian or Chamorro	❑Other_____	❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary?

Verification Answer to the Chosen question: _____
Answers must be at least 6 characters.

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker ***If yes, how often do you smoke:*** ❑ Current every day smoker ❑ Current sometimes smoker ***If yes, what is your level of interest in quitting smoking?***

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest *Very Interested*

Current medications, including frequency and dosage if known. If there are no current medications, Check here: ☐

		Start Date			Start Date
1)			**4)**		
2)			**5)**		
3)			**6)**		

List any known allergies you have had to any medications. If no allergies are known, check here: ❑

List Any Family Health History and Whom It Is/Was: Grandmother (maternal or paternal), Grandfather (maternal or paternal), Mother, Father, Brother, Sister etc.

☐**Stroke** _____ ☐**Arthritis** _____ ☐**Genetic Disease** _____
☐**Cancer** _____ ☐**Depression** _____ ☐**Osteoporosis** _____
☐**Diabetes** _____ ☐**Substance Abuse** _____ ☐ **Hypertension** _____

Has any doctor diagnosed *you* with Hypertension presently? ❑ Yes ❑ No If yes, describe: _____

Has any doctor diagnosed *you* with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II ***If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?*** ❑ Yes ❑ No ❑ Not Sure ***If yes, other comments regarding Diabetes:*** _____

If you would like to keep up on closings due to weather or other circumstances; as well as valuable health information, please take a moment and "Like" us on Facebook right now, right here:

Go to the Top Right Hand Corner of our Webpage: ADVANCED CARE CHIROPRACTIC AND WELLNESS CENTER http://www.advancedcareva.com/

or go *directly to:* https://www.facebook.com/AdvancedCareVa

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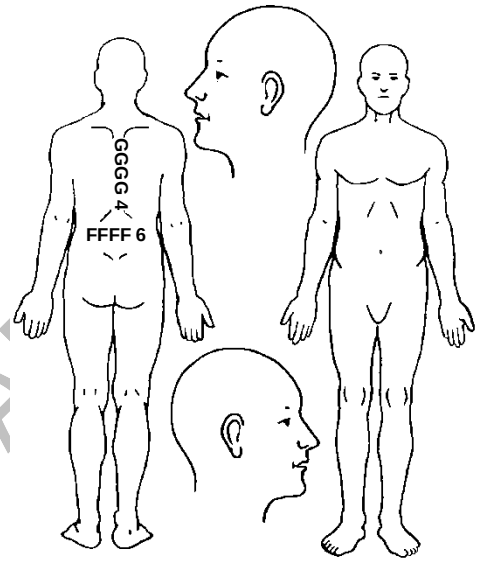
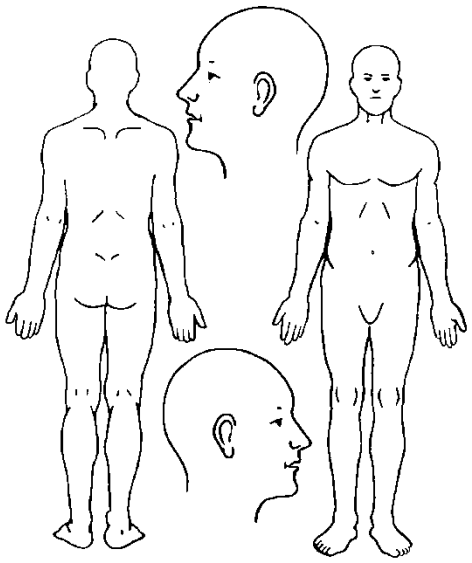
PAIN ASSESSMENT RECORD

In order for us to best serve you, and so that we may determine the progress of your present condition, please provide us with the following information. **PLEASE PRINT**

Name:_____ File No:_____ Date: _____

Current Pain Record

1. List your present Symptoms: _____
2. Is your condition: ☐ Improved ☐ Staying the same ☐ Getting worse
3. Does your pain interfere with: Work ☐Yes ☐No Home Activity ☐Yes ☐No School Activity ☐Yes ☐No
4. Type Of Pain:
   ☐ A: Sharp ☐ B: Tingling ☐ C: Throbbing ☐ D: Numbness ☐ E: Aching ☐ F: Shooting
   ☐ G: Dull ☐ H: Burning ☐ I: Cramping ☐ J: Stiffness ☐ K: Swelling ☐ L: _____
5. Please mark your area(s) of pain with the letter (A, B, C etc.) associated with the Type of Pain you checked above. Indicate the degree of pain by using a scale from 1 (discomfort) to 10 (extreme pain) as seen in the example below:

EXAMPLE ONLY	Show Us Where It Hurts
	

Doctor/Patient Comments:

Patient's Signature: (email equivalent to signature) Date:

_____ _____

FINANCES AND INSURANCE OFFICE POLICY

Outstanding healthcare for every patient is the primary goal of Advanced Care. Another goal of ours is to communicate clearly to all patients the financial guidelines related to a patient's treatment in order to avoid future misunderstandings or disagreements related to the patient's financial responsibility. These guidelines apply to all patients being seen at Advanced Care.

The patient is reminded that insurance coverage is an agreement between the policyholder and their insurance company. The information verified by your insurance company is provided to us by your insurer ***and is not considered a guarantee of payment.*** Please use this information and call your insurance company to ensure its accuracy and completeness.

Advanced Care will make every effort to bill the patient's insurance in a timely manner, but the patient or the ***patient's guardian/guarantor is ultimately responsible for all payments of any past, present and/or future charges*** including medical procedures, therapeutic modalities and adjustments generated by all office visits which are not paid by his/her insurance company. The patient is responsible for their self, their spouse and/or their children for all services rendered at Advanced Care.

Patients are expected to bring their insurance cards and a photo ID to each visit and to be sure to give Advanced Care registration personnel updated and accurate insurance information for each visit and it will be the sole responsibility of the guarantor to pay in full at each visit.

Patients are expected to confirm with their insurance companies that Advanced Care physicians are part of their insurance network of physicians. If not, the patient may generally see an Advanced Care physician on an "out-of-network" basis, but with higher out-of-pocket expense. It is the patients' responsibility to determine all limitations on physicians' visits and/or any other services imposed by their insurance company.

Patients are expected to pay at the time of service all amounts known not to be covered by their insurance company. These amounts include co-payments, co-insurance, and/or deductibles. Patients with high-deductibles are expected to pay a minimum of $150 at their time of service and at each visit thereafter until their deductible has been met. Payments may be made by Visa or MasterCard.

Coverage for Medicare patients only covers the cost of Chiropractic adjustments designed to help correct vertebral subluxations. An exam is necessary to identify the presence of vertebral subluxations. Medicare requires this. But Medicare does not pay for the cost of the exam or any needed x-rays. The cost for the exam and any needed x-rays for the first visit is $150.00. Please see our pamphlet regarding your financial responsibilities for Medicare.

Some patients will be required by their insurance company to obtain a "referral" from their Primary Care Physician authorizing their visit to the Advanced Care physician. It is the patient's responsibility to obtain this referral and to be sure that the referral is communicated to Advanced Care ***before*** the patient's first visit. A patient presenting at Advanced Care without a required referral will be expected to pay $150.00 at registration for their office visit and any additional charges at the end of their visit. Patients are reminded that many Primary Care Physician offices will not provide a retroactive referral.

If you have been involved in an auto accident/injury on the job, you must immediately update your finances for reimbursement for services rendered by Advanced Care. Your health insurance may not pay for these services, but you may be able to run these services through your auto med-pay or through your employers' workman's compensation program. Please know that if you fail to update this status and your health insurance denies payment due to an auto accident/injury on the job, you will be held responsible for payment on all services rendered but denied by your health insurance company.

Be sure to look at your ***Explanation of Benefits*** (EOBs) as soon as you receive them from your insurance company. There will be an area where it will state the patient's responsibility. Make sure you send this amount to Advanced Care immediately to avoid any interest or collections charges for services rendered. An APR of 1.5% per month or 18% annually will be added to any balance due past 30 days from first date of service and each month thereafter until the account is paid in full. Patient accounts which have not been paid by the patient and/or insurance company for 90 or more days since the first office visit will be referred to a collection agency and/or attorney for collection. In addition to the account balance, the patient agrees to pay for any and all costs of collection or legal fees related to these collection efforts. All copies for medical records request or receipts are as follows: 50 cents per page up to 50 pages, 25 cents a page thereafter and a $10 processing fee. For an additional fee of $30 x-rays can be purchased on disk. All requests must be pre-paid and a 7 day advanced notice must be given. Any returned check and/or declined credit card will be a service fee of $75 or maximum allowed by law. All patients must give a 24 hour notice for cancellations to avoid a service charge as follows; New patient appointments are $50*, Routine Chiropractic appointments are $25*, Spinal Decompression appointments are $68*.

Please note: *The software audit system automatically applies the charges and sends the bill for processing to be mailed from the clearinghouse the day it occurs and it cannot be stopped, changed or deleted by the office staff.

Also, Please Be Sure To Notice – Cell Phone Use Is Not Allowed While In The Office.

I have read, understand and agree to the terms for treatment set forth by the Finances and Insurance Office Policy for Advanced Care.

Patient Signature:_____Date: _____

1. What do you do for a living? What are your job activities and duties?

_____

2. Have you ever been in the Military? ☐Yes ☐No If so, when?

_____

3. Have you recently had any broken bones? ☐Yes ☐No If so, when and how?

_____

4. Have you had any type of surgery in the last 4 months? ☐Yes ☐No If so, what was it for and when was the surgery?

_____

5. Have you ever had any spinal surgery? ☐Yes ☐No If so, when?

_____

6. When did these symptoms first present with pain?

_____

7. Who is your Primary Care Physician (PCP)? _____

8. Have you ever seen a Chiropractor and was it for this condition? ☐Yes ☐No If so, who and when?

_____

9. Have you ever seen a Physical Therapist and was it for this condition? ☐Yes ☐No If so, who and when?

_____

10. Have you seen any other type of Specialists and was it for this condition? ☐Yes ☐No If so, who and when?

_____

11. Have you had an ☐X-ray, ☐CT scan or ☐MRI of your spine for this condition in the last 12 months? ☐Yes ☐No If so, what body part?

_____

12. Did you have any kind of injury or accident leading to these symptoms? ☐Yes ☐No
☐Work-Related Injury ☐Automobile Accident If so, please briefly describe below.

_____

13. When do these symptoms present with the most pain? Please briefly describe below.
☐In the morning ☐In the Evening ☐Standing ☐Sitting ☐Laying down ☐Activities

_____

14. What do you do to relieve these symptoms? Please briefly describe below.
☐Ice ☐Heat ☐NSAIDS ☐Prescription Drugs ☐Resting ☐Stretching ☐Walking

_____

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Notice of Privacy Practices - Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our privacy officer at 745-8745.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Patient or Legally Authorized Individual Signature

_____

Print Patient's Full Name _____

Please List Any and All Authorized Persons to Have Access to Your Healthcare Records:

1. _____ Relation to You: _____
2. _____ Relation to You: _____
3. _____ Relation to You: _____
4. _____ Relation to You: _____
5. _____ Relation to You: _____

Password All Authorized Persons Must Have Before Obtaining Information to Your Healthcare Records:

_____

This form will be retained in your medical record.