CHIROPRACTIC first
FAMILY WELLNESS CENTER

CONFIDENTIAL NEW MEMBER INFORMATION

Date:_____

Name:_____ Best Contact Number_____Other_____
Address:_____City/State/ZIP:_____ _____
D.O.B.:_____ Age: ____ Who may we thank for referring you? _____
Email: _____Social Security Number:_____
Is this for the whole family? Family:_____ Self: _____ Medicare? Yes No Car Accident? Yes No
Primary reason for consulting our office:_____
Occupation:_____ Employer: _____
Sex: M / F Single / Married / Divorced / Widowed Spouse's Name:_____
Name and Ages of Children:_____
Your hobbies/interests/activities: _____
Do you exercise? NO YES: How often? _____ What type?_____
Rate your diet: Healthy Average Poor Do you use Vitamins/Supplements: YES NO_____
Alcohol: Never/Rare/Moderate/Daily Smoker? No Yes ___# packs/day since year: ___ Past smoker? No Yes
What is the present reason for consulting our office?
□ Symptom Relief □ Maintaining Your Current Level of Health □ Optimum Wellness

Previous chiropractic care? YES NO If yes, Dr.'s Name: _____ Last visit? _____
Other doctors you are currently seeing: _____
Current medications:_____
Over the counter drugs taken in the past 3 months: _____
List all surgeries:_____
List all accidents and falls: _____

Health is the most valuable asset in the world – YOU and YOUR FAMILY'S. Healing includes taking responsibility for that health. Aspects of this responsibility are attending the classes, following your care plan, and meeting your financial obligations. The insurance industry pays for the treatment of symptoms and disease. We do not treat symptoms and disease. We offer true healing through Chiropractic Care. Therefore, we operate on a fee for service basis. However, you may submit your claims for your own personal reimbursement. Chiropractic care is not a treatment nor cure of disease. Chiropractic care is for the restoration and maintenance of full function and communication within the body, from the brain to every cell in the body, so that you may express your full potential for life and healing.

I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment.

I hereby request and consent to the performance of chiropractic adjustments, other chiropractic procedures and if necessary diagnostic x-rays on me by the doctor of chiropractic authorized by Chiropractic First. I further understand and am informed that, as in all health care, there are some slight risks to treatment and do not expect the doctor to be able to anticipate or explain all risks and complications; and 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 interest. I have read this consent and intend this consent form to cover the entire course of my care and any care in the future.

Signature:_____ Witness:_____
Print:_____ Date:_____

Medicare Beneficiaries:

Due to common degenerative changes in senior citizens, we only provide non-manipulation forms of adjustment for Medicare beneficiaries. These mobilization techniques are statutorily non-covered services under Medicare. As a result, we are not required and will not bill these services on your behalf to the Medicare program.

Initials: _____

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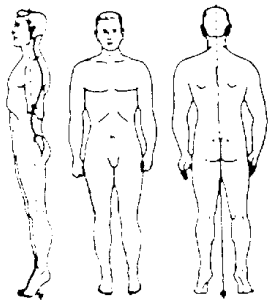
HEALTH HISTORY FORM

Patient's Name_____Date_____/_____/_____
Height_____ Weight_____ Please circle: Right Handed / Left Handed

*****If you are NOT experiencing ANY symptoms, please go to Section B: Health History****

Section A: Current Problem Please answer the following questions regarding your **current** problem:

Please mark on the picture, where you have any problems.



Date of Onset: _____ Cause of Condition (if known)_____
How often during the day do you experience this?
☐ 0-25% ☐ 25-50% ☐ 50-75% ☐ 75-100%
Describe the pain: ☐ sharp ☐ dull ☐ achy ☐ stiff ☐ shooting ☐ burning ☐ spasm
How severe is this problem? No Pain 1 2 3 4 5 6 7 8 9 10 Extreme
Since the onset, is the pain? ☐ worse ☐ better ☐ same ☐ on & off
Is there anything that makes it worse? ☐ standing ☐ sitting ☐ lying down ☐ motion
Is there anything that makes it better? ☐ standing ☐ sitting ☐ lying down ☐ motion
Is this problem? ☐ Better or ☐ Worse ☐ AM or ☐ PM ☐ Neither
Are any systems involved? ☐ Digestive ☐ Cardiovascular ☐ Respiratory ☐ Elimination ☐ Reproductive
Does the pain cause you to? ☐ Lose sleep ☐ Be short tempered ☐ Miss work ☐ Miss play ☐ Lose focus
What has this problem kept you from enjoying? _____
Have you had a similar condition in the past? Y N If yes, explain: _____
What treatment(s) have you already had for this problem?
Medication Surgery Physical Therapy Chiropractic None Other:_____
What was the outcome of this treatment?_____
Any other facts about your current problem or pain: _____

Is there any chance you could be pregnant? YES NO Date of last menstrual period:_____

Section B: Health History (Please ✓ if you have had or are currently experiencing any of the following:)

☐ Anxiety	☐ Anemia	☐ Arthritis	☐ Thyroid Problems	☐ Bowel Problems
☐ Cancer	☐ HIV/AIDS	☐ Tuberculosis	☐ High Blood Pressure	☐ Heart Trouble
☐ Diabetes	☐ Hepatitis	☐ Insomnia	☐ Venereal Disease	☐ Muscular Dystrophy
☐ Epilepsy	☐ Dizziness	☐ Convulsions	☐ Multiple Sclerosis	☐ Rheumatic Fever
☐ Neuritis	☐ Asthma	☐ Scarlet Fever	☐ Digestive Problems	☐ Sinus Trouble
☐ Allergies	☐ Backaches	☐ Numbness	☐ Frequent Colds	☐ Nervousness
☐ Stroke	☐ Depression	☐ Headaches	☐ Cold Hands/Feet	☐ Restless Sleep
☐ Ulcer	☐ Irritability	☐ Impulsivity	☐ Low Pain Threshold	☐ Fibromyalgia
☐ Hernia	☐ PMS	☐ Bruising	☐ German Measles	☐ Osteoporosis
☐ Nausea	☐ Swelling	☐ Mood Swings	☐ Chronic Fatigue Syndrome	☐ Infertility

Describe other details about YOUR Past Medical History:_____
_____

Section C: Family History (Your Blood Relatives Only)
☐ Diabetes ☐ Heart Disease ☐ Cancer ☐ Thyroid Problems ☐ Stroke ☐ Multiple Sclerosis
☐ Other: _____

(For Doctor's Use Only)
Blood Pressure_____ Pulse_____ Respiration_____ Temperature _____

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NOTICE OF PRIVACY FOR:
PATIENT'S PROTECTED HEALTH INFORMATION

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

This office abides by the terms described in this policy.
This office uses and discloses your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to insurance companies or Worker's Compensation Claim to verify that treatment has been rendered.
- To determine patient's benefits in a health care plan.
- Releasing information required by State or Federal Public Health law.
- To assist in overcoming a language barrier when caring for a patient.
- Business associates providing written assurances for your privacy have been attained.
- Emergency situations.
- Abuse, neglect, or domestic violence.
- Appointment reminders to household members or answering machines.
- Mailings for appointment reminders, birthday cards, bills and other correspondence.
- Sign-In logs may be disclosed to verify office visits.

Any other uses or disclosures will only be made with your specific written prior authorization.
Please note the Doctors of Chiropractic First utilize an open area for the delivery of care and it is understood that if a patient/client needs to speak on a matter of personal privacy it is solely the responsibility of the patient to request a private area for the discussion to take place.

You have the right to:

- Revoke authorization, in writing at any time by specifying what you want restricted and to whom.
- Speak to our privacy officer who is: Dr. Andrew Williamson
- Inspect, copy and amend your protected health information and amend it as allowed by law.
- Obtain an accounting of disclosures of your protected health information.
- To render a complaint to our privacy officer or the Secretary of Health and Human Services.

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected by health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding.

_____	_____	_____
Name of Patient (print)	Signature of Patient/Legal Representative	Date

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NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS (NEMB)

There are items and services for which Medicare will not pay

- Medicare does not pay for all of your health care costs. Medicare only pays for covered benefits. Some items and services are not Medicare benefits and Medicare will not pay for them. When you receive an item or service that is not a Medicare benefit, you are responsible to pay for it, personally or through any other insurance that you may have. The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself.
- Before you make a decision, you should read this entire notice carefully.
- Ask us to explain, if you don't understand why Medicare won't pay.
- Ask us how much these items or services will cost you (See non-covered service fees on reverse)

Medicare will not pay for:

☐ The following services when performed by a licensed Doctor of Chiropractic:

- Evaluation and Management Services to include examinations necessary to prepare treatment plans required to justify the medical necessity of covered services such as manipulation.
- Radiographs/X-Rays
- Physical Medicine Modalities such as the application of hot/cold packs, electric stimulation, ultrasound, mechanical traction or hydrotherapy.
- Physical Medicine Procedures such as manual therapy, therapeutic exercises and/or therapeutic activities.
- Neuromuscular Diagnostic Services including physical performance testing, range of motion testing.
- Electrodiagnostic testing including sEMG, EMG, NCV, SSEP.

☐ Maintenance manipulation.

CMS defines maintenance manipulation as follows:

Maintenance therapy includes services that seek to **prevent disease**, **promote health** and prolong and enhance the quality of life, or **maintain or prevent deterioration of a chronic condition**. When **further clinical improvement cannot reasonably be expected from continuous ongoing care**, and the chiropractic treatment becomes **supportive rather than corrective in nature**, the treatment is then considered maintenance therapy. [emphasis added]

☐ **1. Because it does not meet the definition of any Medicare benefit.**

☐ **2. Because of the following exclusion * from Medicare benefits:**

- ☐ Non Medically Necessary Services
- ☐ Personal comfort items.
- ☐ Orthopedic shoes and foot supports (orthotics).
- ☐ Health care received outside of the USA.
- ☐ Routine physicals and most tests for screening.
- ☐ Cosmetic surgery.
- ☐ Routine foot care and flat foot care.
- ☐ Services by immediate relatives.
- ☐ Services under a physician's private contract.
- ☐ Services required as a result of war.
- ☐ Routine eye care, eyeglasses and examinations.
- ☐ Dental care and dentures (in most cases).
- ☐ Services for which the patient has no legal obligation to pay.
- ☐ Services paid for by a governmental entity that is not Medicare.
- ☐ Items and services furnished to an individual who is a resident of a skilled nursing facility (a SNF) or of a part of a facility that includes a SNF, unless they are furnished under arrangements by the SNF.
- ☐ Outpatient occupational and physical therapy services furnished incident to a physician's services.

*** This is only a general summary of exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.**

Patient Signature _____ Date _____

Form No. CMS-20007 (January 2003)

603 East Ridgeville Blvd., Mount Airy, MD 21771 (301) 829-4040