THE HEAD AND NECK CENTERS OF EXCELLENCE

FOCUSED CARE FOR HEAD, NECK, & TMJ COMPLAINTS

The Head & Neck Centers Of Excellence Patient Qualification Intake Form

Welcome to The Head & Neck Centers Of Excellence by Dr. Smith Chiropractic. To accurately assess you and to determine if you are a true candidate for our care, it is important that you fill out this form as thoroughly as possible. Thank You.

Today's Date _____

PERSONAL INFORMATION

Name _____ Age _____ Birthday _____ Sex M F
Address _____ Social Security Number _____
City_____ State _____ Zip Code _____
Email Address _____
Home Phone _____ Work Phone _____ Cell Phone _____
Best Place to Reach You (circle one) Home / Work / Cell May we leave a voicemail message for you? Yes No
Employer _____Occupation_____ Length of Employment _____
Marital Status S M W D Spouses Name _____

REFERRAL

How did you hear about The Head & Neck Centers Of Excellence ? _____

INSURANCE INFORMATION

Do you have health insurance? ☐ No ☐ Yes - if yes, please continue

Insurance Company _____ Address _____

Group Number _____ Member ID: _____ Ins. Phone Number _____ - _____ - _____

Are you covered by any additional insurance? ☐ No ☐ Yes - if yes, please continue

Policy holder's name _____ DOB ____/____/____

Insurance Company _____ Address _____

Group Number _____ Member ID: _____ Ins. Phone Number _____ - _____ - _____

Payment acknowledgement (please sign). I understand and agree that health and accident insurance policies are an arrangement between insurance carriers and myself. I also understand that this office will prepare any forms and reports necessary to assist me in making a collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on my receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care treatment, any fees for professional services rendered to me or my dependent will be immediately due and payable.

Patient's Signature _____ **Date** _____

Insured's Signature _____ **Date:** _____

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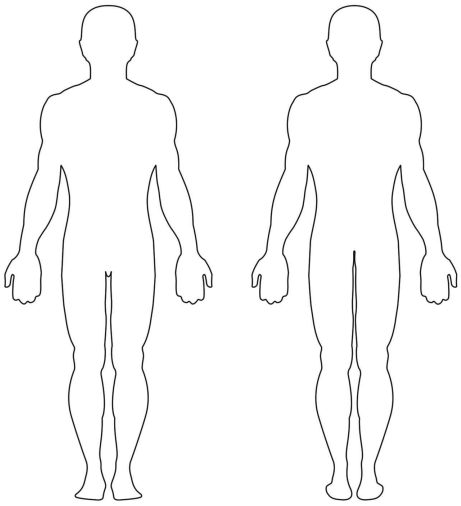
What symptoms are you experiencing? _____

Would you consider this problem to be (circle one): MINIMAL (Annoying but causing NO limitations)
SLIGHT (Tolerable but causing a little limitation)
MODERATE (Sometimes tolerable but causing limitations)
SEVERE (Causing Significant limitations)
EXTREME (Causing near constant (>80% of the time) limitations)

Please indicate areas of pain using the chart below:

Front Back



1. What do you think is causing the pain?

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2. Since your pain became this severe what are some activities that you are not able to do?

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3. How has your life changed since your condition became a problem?

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4. What kind of treatments have you received?

Physical Therapy: How Long _____ When(approx) _____
Medication(s): _____ When(approx) _____
Surgery: Type_____ When(approx) _____
Other_____

5. When did you receive these treatments and for how long?

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6. Did any of these treatments work? If so which one(s)? For how long?

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7. What activities/movements are guaranteed to make it worse?

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8. Please describe the quality of the pain. (Sharp, Dull, achy, toothache, shooting, stabbing, numb, tingling, etc...)

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9. Is it worse in the morning or is it worse as the day progresses?

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10. When is the VERY FIRST time you recall having this problem?

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Due to Your Main Problem.....

Have you lost any time from work?

How much time and what tasks have been limited? _____

Have you been able to complete chores/tasks at home?

Have you lost any time with your family?

Have you been able to partake in your leisure activities? (Hobbies, Travel, Sports, etc...)

Considering the amount of pain/discomfort you have had THIS week, how long has your problem been this severe?

_____

Average pain intensity:

Last 24 hours: no pain 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 1 2 3 4 5 6 7 8 9 10 worst pain

List ANY surgeries that you have had and the corresponding dates:

Signature: _____ **Date:** _____

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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, disclosed and how you can get access to this information. Please review 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 for Workers Compensation to verify that treatment has been rendered.
- To determine a 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.
- Emergency situations
- Abuse, neglect, or domestic violence.
- Appointment reminders to household members or answering machines.
- Sign-in sheets may be disclosed to verify office visits.
- To send out birthday cards and newsletters.

Any other uses or disclosures will only be made with your specific written prior authorization.

You have the right to:

- Revoke authorization in writing at any time by specifying what you want to be restricted and to whom.
- Speak to our privacy officer regarding privacy issues.
- Inspect, copy, and amend your protected health information.
- To render a complaint to our privacy officer.

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

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

Patient's Signature _____ **Date** _____

Patient Name _____ **File No:** _____
(Staff use only)

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ASSIGNMENT OF BENEFITS

I authorize and direct that payment be made directly to Dr. Andrew Smith for any and all insurance benefits or reimbursement for services rendered which amounts would otherwise be payable to me under any insurance or pre-paid healthcare plan.

_____ _____

Date Patient / Legal Guardian Signature

AUTHORIZATION AND CONSENT

I authorize the release of any information concerning my health and health care services to my insurance company(s), pre-paid health plan, or Medicare.

_____ _____

Date Patient / Legal Guardian Signature

PAYMENT AGREEMENT

I understand that there is no guarantee that my insurance company(s) or pre-paid health plan will cover or pay for all my charges. No withstanding denials, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

_____ _____

Date Patient / Legal Guardian Signature

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INFORMED CONSENT

Doctor - Patient Relationship in Chiropractic

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of Chiropractic, osteopathy, and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from Chiropractic health care services.

ANALYSIS

A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such complexes are found, Chiropractic adjustments and ancillary procedures may be given to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherited recuperative powers. Due to the complexities of nature, no doctor can promise you specific results.

DIAGNOSIS

Doctors of Chiropractic are experts in Chiropractic diagnosis, the VSS and VSC, though they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her total condition. Your doctor may express an opinion as to whether you should take this step or not, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

The patient seeking Chiropractic care gives the doctor full permission to care for the patient in accordance with all testing, diagnosis and analysis performed. Chiropractic adjustments and other clinical procedures offered are generally successful. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor will not perform a Chiropractic adjustment or any other procedure if he/she is aware of any such risk. It is the full responsibility of the patient to make it known, or seek health care procedures to determine, whether he/she is suffering from: latent pathological defect, illnesses, or deformities which the Chiropractor would not otherwise be aware of. The patient should seek the appropriate specialist for any diagnostic and clinical procedures. The doctor of Chiropractic is licensed in a specialized practice and may collaborate with other types of providers in your health care regime.

RESULTS

The purpose of Chiropractic care is to promote natural health through the reduction of VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficiency of the Chiropractic procedures. In most cases, the response is gradual. Chiropractic and medicine may never be exact in providing answers to all conditions, but will make strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or concerns you may have with the doctor. Your signature below indicates that you have read, understand, and agree with the terms of the doctor-patient relationship in chiropractic.

Patient's Signature _____ **Date** _____