BACK IN MOTION, P.S.
CHIROPRACTIC

# PATIENT APPLICATION FORM

WELCOME and THANK YOU for applying as a patient in our clinic. We are a very unique team specializing in researched-based spinal and postural rehabilitation. These methods have enabled our patients to achieve their optimal health; even when many other systems have failed. Because of this specialized approach, we may not accept you as a patient until we are absolutely certain we know the cause of your condition, that we can perform the necessary tests to establish an optimal rehab program for you and are completely confident we can help you recover your health. Please know if we do accept you as a patient, we will then make specific recommendations based upon our understanding that your health will become your TOP PRIORITY. Thank you again for applying as a patient in our clinic. Please note: paperwork must be completed in pen.

_____

***PATIENT NAME***

_____

***DATE COMPLETED***

## Patient Information

Name: _____ (Age) _____ Gender: M F

Home Address: _____ Home Phone: ( ) _____

City, State, Zip: _____ Work Phone: ( ) _____

Email Address: _____ Cell Phone: ( ) _____

Birth Date: _____ /_____ /_____ Social Security #: _____ - _____ - _____ Marital Status: S M D W

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

Primary Care Physician Name: _____ Specialty: _____

Primary Care Physician address: _____ PCP Phone: _____

Primary Care Physician group (i.e. Rockwood, Providence, Kaiser, etc.): _____

## Purpose For This Visit

Reason for this visit: _____

Is this related to an accident or specific injury (other than auto or work-related)*? ☐ Yes ☐ No If yes, when: _____ /_____ /_____

***If your symptoms are the result of an auto accident or work-related injury, please ask the front-desk person for the corresponding application.***

Describe: _____

**Please use the *General Symptoms Chart* on the next page to provide a detailed notation of your symptoms.**

When did these symptoms begin? _____ / _____ / _____ Are they: ☐ Constant ☐ Intermittent ☐ Activity-related

Are they getting worse? ☐ Yes ☐ No Do they interfere with: ☐ Work ☐ Sleep ☐ Hobbies ☐ Daily Routine

Explain: _____

What activities aggravate your symptoms? _____

Is there anything that relieves your symptoms? ☐ Yes ☐ No If yes, explain: _____

Have you experienced these symptoms before (if not accident/injury related)? ☐ Yes ☐ No

If yes, explain: _____

Have you been treated for this? ☐ Yes ☐ No When were you last treated? _____ /_____ /_____

Who did you see? _____

What treatment was performed? _____

How did you respond? _____

## Experience with Chiropractic

Have you seen a Chiropractor before? ☐ Yes ☐ No Who? _____

Reason for visit(s): _____

Did your previous chiropractor take 'before' and 'after' x-rays? ☐ Yes ☐ No What was the diagnosis? _____

Did he or she recommend a specific course of treatment? ☐es ☐o Did they recommend a Home Health Care program? Ye☐ No☐

If yes, what? _____ How long were you treated? _____ Last treatment: _____/_____ /_____

How did you respond? _____

Are you aware of any poor posture habits? ☐ Yes ☐ No Is there any history of spinal problems in your family? ☐ Yes ☐ No

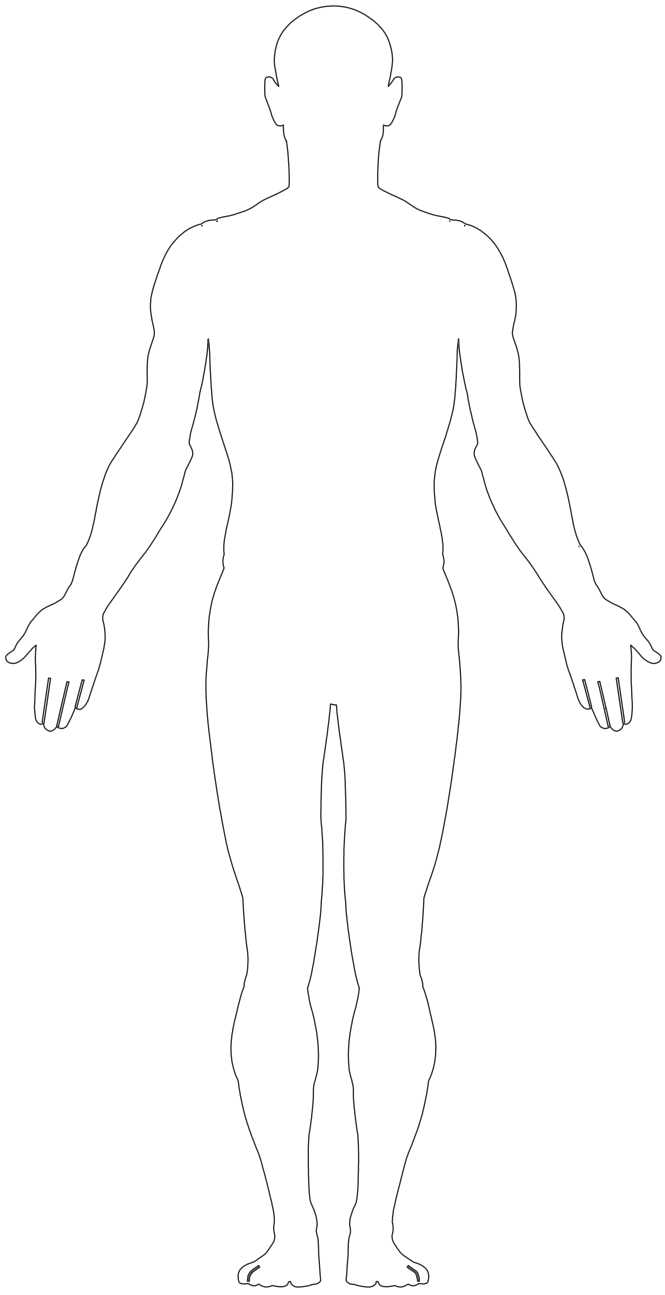
If yes, explain: _____

# GENERAL SYMPTOMS CHART

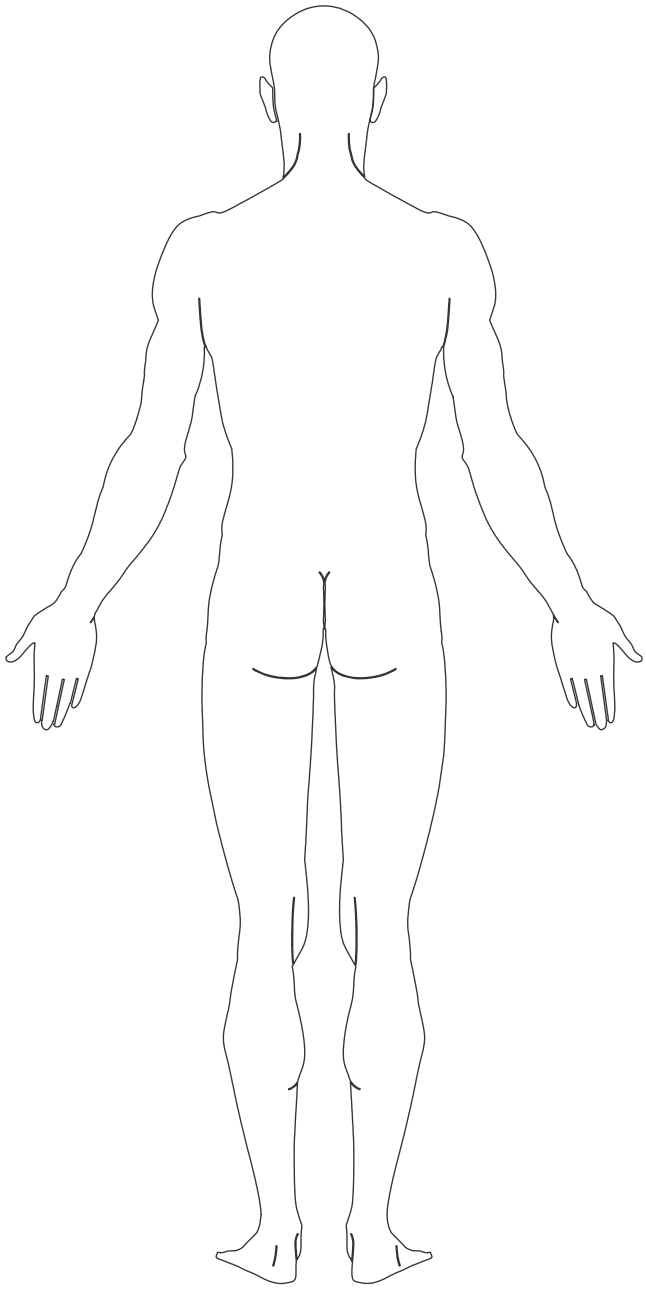
Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

**Please rate each region on the VAS pain scale 1-10, 10 being the most severe.**

| | | | | | |
|---|---|---|---|---|---|
| A = ACHE | | G = STABBING | | N = NUMBNESS | |
| B = BURNING | | M = SPASMS | | T = TINGLING | |
| P = PINS & NEEDLES | | F = STIFFNESS | | O = OTHER | |



FRONT



BACK

If you marked "O" for Other on any part, please explain below:

## Health & Lifestyle

Do you exercise? ☐ Yes ☐ No How often? _____ day(s) per week; Other: _____

What activities? ☐ Walking ☐ Running/Jogging Weight Training Cycling Yoga Pilates Swimming Other: _____

Do you smoke? ☐ Yes ☐ No How much? / How often? _____

Do you drink alcohol? ☐ Yes ☐ No How much? / How often? _____

Do you drink coffee? ☐ Yes ☐ No How much? / How often? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

If yes, please list: _____

## Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span.[1] Please answer the following questions accurately so we may determine the full extent of your condition.

### CERVICAL SPINE (NECK)

Misalignment of the individual vertebrae or distortion of the complete cervical curve (neck) originating in the neck or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms currently or in the past?

***Please indicate (C) = Current, (P) = Past next to all conditions you've experienced or both if applicable.***

| | | |
|---|---|---|
| ____ Neck Pain | ____ Headaches | ____ Sinusitis |
| ____ Pain in shoulders/arms/hands | ____ Dizziness | ____ Allergies/Hay fever |
| ____ Numbness/tingling in arms/hands | ____ Visual disturbances | ____ Recurrent colds/Flu |
| ____ Hearing disturbances | ____ Coldness in hands | ____ Low Energy/Fatigue |
| ____ Weakness in grip | ____ Thyroid conditions | ____ TMJ/Pain/Clicking |

Please explain: _____

_____

_____

_____

### THORACIC SPINE (UPPER BACK)

Misalignment of the individual vertebrae or distortion of the upper thoracic curve (upper back) originating in the upper back or as a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms currently or in the past?

***Please indicate (C) = Current, (P) = Past next to all conditions you've experienced or both if applicable.***

| | |
|---|---|
| ____ Heart Palpitations | ____ Recurrent Lung Infections/Bronchitis |
| ____ Heart Murmurs | ____ Asthma/Wheezing |
| ____ Tachycardia | ____ Shortness of Breath |
| ____ Heart Attacks/Angina | ____ Pain on Deep Inspiration/Expiration |

Please explain: _____

_____

_____

_____

1. *Postural and Degenerative Kyphosis: Freeman JT. Posture in the Aging and Aged body. JAMA 1957, Oct 19: 843-846.*

# Health Conditions *continued*...

## THORACIC SPINE (MID BACK)

Misalignment of the individual vertebrae or distortion of the mid thoracic curve (mid back) originating in mid back or as a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms currently or in the past?

***Please indicate (C) = Current, (P) = Past next to all conditions you've experienced or both if applicable.***

____ Mid Back Pain ____ Nausea ____ Diabetes

____ Pain in Ribs/Chest ____ Ulcers/Gastritis ____ Hypoglycemia/Hyperglycemia

____ Indigestion/Heartburn ____ Reflux

____ Tired/Irritable after eating or when not having eaten for a while

Please explain: _____

_____

_____

## LUMBAR SPINE (LOW BACK)

Misalignment of the individual vertebrae or distortion of the lumbar curve (low back) originating in the low back or as a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms currently or in the past?

***Please indicate (C) = Current, (P) = Past next to all conditions you've experienced or both if applicable.***

____ Pain in hips/legs/feet ____ Weakness/injuries in hips/knees/ankles ____Low back pain

____ Numbness/tingling in legs/feet ____Recurrent bladder infections ____ Coldness in legs/feet

____ Frequent/difficulty urinating ____ Muscle cramps in legs/feet ____ Sexual dysfunction

____ Constipation/Diarrhea ____ Menstrual irregularities/cramping (females)

Please explain: _____

_____

_____

## OTHER

Please list any health conditions not mentioned: _____

_____

_____

_____

Please list any medications (include name, dose, for what condition, and how long you've been taking it): _____

_____

_____

_____

Please list any surgeries (include type of surgery and date it was performed): _____

_____

_____

_____

COVID 19:

Have you been vaccinated for COVID-19? _____ Yes _____ No

Did you receive 1 or more boosters for COVID-19? _____ Yes _____ No

Have you ever had an active COVID-19 infection? _____ Yes _____ No _____ Unsure

# Family Health History

Have any of your family members ever been diagnosed with the following ***(please indicate "Y" for You, and "O" for Other than you, or both if applicable)***:

| | | | |
|---|---|---|---|
| ____ Diabetes | ____ Varicose Veins | ____ Neurological Problems | ____ Lung Disease |
| ____ Rheumatic fever | ____ Circulatory Problems | ____ Stroke | ____ Heart Murmur |
| ____ High Blood Pressure | ____ Heart Disease | ____ Cancer | ____ Osteoporosis |
| ____ Kidney Disease | ____ Paralysis | ____ Migraine Headaches | ____ Arthritis |
| ____ Liver Disease | ____ Metal Implants | ____ Infectious Disease | ____ Gall Bladder |
| ____ Broken bones/fractures | ____ Appendectomy | ____ Tonsillectomy | ____ Hernia |
| ____ Pneumonia/Bronchitis | ____ Polio | ____ Tuberculosis | ____ Anemia |
| ____ Whooping Cough | ____ Chicken Pox/Shingles | ____ Mumps | ____ Measles |
| ____ Thyroid Problems | ____ Smallpox | ____ Influenza | ____ Pleurisy |
| ____ Blood Sugar Problems | ____ Epilepsy/Seizures | ____ Eczema/Psoriasis | ____ Lumbago |
| ____ Lupus | ____ Scoliosis | ____ Depression | ____ Anxiety |

Other: _____

_____

### Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____ /_____ /_____

Patient's Signature _____ Date _____ /_____ /_____

# Authorization of Care

I authorize and agree to allow the doctor and/or his designated staff to work with my spine or the spine of the charge I represent through the use of spinal adjustments, various mechanical traction, and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors and/or staff's specific recommendations at this clinic that I will not receive the full benefit from these programs; and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

I understand and am informed that in the practice of Chiropractic there are some risks to treatment, including but not limited to: fractures, disc injuries, strokes, dislocations, strains, and death. I do not expect the doctor to be able to anticipate and 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 is in my best interest.

Patient's Signature _____ Date _____ /_____ /_____

Patient's Name Printed _____

If patient is a legal charge of limited capacity requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded _____ County, State of Guardianship _____

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.

Guardian Signature _____ Date _____ /_____ /_____

## In Case of Emergency

Name _____ Relationship _____

Work Phone ( )

Home Phone ( )

Cell Phone ( )

## Insurance

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. In cases where benefits are not assignable or in any case where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from this clinic is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically be transferred to your credit card or the extended payment plan.

### *ITEMIZED RECEIPTS, aka. "SUPERBILLS"*

*Our fees and charges are based on the cost of doing business and providing patients with the highest quality of care possible. This office does not participate with any insurance provider or accept such an assignment. Patients are responsible for payment of any services provided. You will be given a receipt with a description of services received, more commonly referred as a "Superbill", along with the related charges that you, in turn, can submit to your own insurance company for possible reimbursement, as well as retain for your personal records.*

### DECLARATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The doctor's office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account. I understand that the office reserves the right to charge me for an office visit minimum of $75.00 for which I do not show up or give a 24 hour cancellation notice for any chiropractic adjustment or consultation. I also understand that the office reserves the right to charge a finance charge of 1 ½ % each month on bills past 30 days and that I will be sent to collections on bills past 60 days. I understand that there is a $40.00 charge for all returned checks, and that all payment is due upfront, or at the agreed upon timing according to the paperwork signed by me at the time of my financial consultation.

I understand there could be some services that my insurance company does not cover. If this is the case I am willing to pay for these services. ☐ Yes ☐ No

## HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

## HIPAA *continued…*

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Patient's Signature _____ Date _____ /_____ /_____

Signature of Person Authorizing Care (if different from patient):

_____ Date _____ /_____ /_____

Relationship to Insured _____ Date of Birth _____ /_____ /_____

Employer _____

**Primary Insurance Company** _____ Policy# _____

Address _____ Phone # (  ) _____

Insured's Name _____ Insured's Social Security #: _____ - _____ - _____