SPINE ALIGN CHIROPRACTIC CENTER
DR. TODD L. REESE & DR. DEVIN P. SCORESBY

WELCOME

The doctors and staff of **Spine Align Chiropractic Center** welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

PATIENT IDENTIFICATION

Patient Full Name______________________________

Date of Birth_____________ Male ( ) Female ( )

Street____

City_______________ State_____ Zip___________

Phone (Home) ______________________________

Phone (Cell)______________________________

Email____

Would you like to receive Text or Email Reminders for your Appointments? Text or Email or None

If Text, who is your wireless provider?______________________________

Spouse's Name______________________________

Your Children's Names are:__________________

____

____

How did you hear about us? Check which box please

- ☐ Existing Patient (who?)__________________
- ☐ Internet (where) ______________________
- ☐ Lecture (which one) ____________________
- ☐ Other ______________________________

Occupation______________________________

Primary Physician___________________________

City_____________________State_____

ACCEPTANCE AS PATIENT

I understand and agree that the doctors of **Spine Align Chiropractic Center** have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process if information gathering so that the doctor can determine whether to accept me as a patient.

______________________________ ______________________________

Signature Date

Guardian Signature Authorizing Care______________________________Date____________

Contact in case of emergency, Name:__________________________Relationship____________

Telephone # ____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: The state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential. Subluxations can also occur in the extremities.

We do not offer diagnosis or treat any disease. We only offer to diagnosis either vertebral subluxation complex and/or neuro-musculoskeletal conditions. However, during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, ______________________ have read and fully understand the above statements. I understand I can speak with the chiropractor regarding the doctor's objective pertaining to my care in this office.

Therefore, I accept chiropractic care on this basis.

______________________________ (signature) ______________________________ (date)

Consent to evaluate and adjust a minor child

I, ____________________ being the parent or legal guardian of ______________________ have read and fully understand the above terms of acceptance and herby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her 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. ________________________

______________________________ (signature) ______________________________ (date)

Spine Align Chiropractic Center
Financial Policy

Thank you for choosing Spine Align Chiropractic Center. We look forward to serving you.

Please initial next to the option that applies to you.

__________ NO INSURANCE - Payment in full is due at the time of service unless a payment agreement has been made. If you are on a monthly payment plan, then the monthly amount is due according to your payment agreement on the date agreed upon. If payments are not made in a timely manner and further arrangements are not made, your account may be sent to collections (more than 3 months delinquent).

_________PRIVATE INSURANCE - (Blue Cross, Blue Shield, AETNA, United Health, etc.) - Copay and coinsurance is due at the time of service. If you know you have not met your deductible, then payment arrangements must be made by the second visit. This payment agreement will allow you to choose when your monthly amount will be due. Non-covered services are amounts that your individual insurance plan does not cover. These will show up on the explanation of benefits (EOB) that will be mailed to you after your insurance is submitted. You will be required to pay for these non-covered amounts in addition your monthly payment agreement.

________MEDICARE ONLY - Copay is due at the time of service. If you know you have not met your deductible, then the full balance of the visit will be due at the time of service unless arrangements are made in advance. The chiropractic deductible for Medicare only insurance is $155. Medicare is contracted to pay for 12 visits in a calendar year.

_______MEDICAID ONLY (Dr. Scoresby) - Medicaid is contracted to pay for 6 visits in a calendar year. Medicaid does not cover any rehabilitative procedures which may include manual therapy, traction and/or others.

______MEDICARE AND SECOND INSURANCE - No payment will be taken at the time of service. If you know you have not met your deductible for both insurances, then arrangements for payment must be made. Any balance that your insurance does not cover we will send a statement to you. If payments are not made in a timely manner and further arrangements are not made, your account may be sent to collections (more than 3 months delinquent).

If you do run into a financial difficulty, please notify our office and we will help you make other arrangements.

Who is responsible for payment? ____

How will you pay for your care? ( ) cash ( ) check ( ) credit card

Insurance Co. ______________________________ Group policy # _______________

Insured's Name ______________________________ Subscriber ID# ___________________

Insured's DOB: ______________________________ Insured's SSN: ____________________

By signing you understand and agree that you will be required to pay for your portion at the time of service unless you have made a monthly payment agreement.

______________________ ____________________

Patient's Signature Date

NOTICE OF PRIVACY PRACTICES

I acknowledge that Spine Align Chiropractic and Scoresby Chiropractic Center "Notice of Privacy Practices" has been provided to me. I understand that I have the right to review Spine Align Chiropractic and Scoresby Chiropractic Center Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practice describes the types of use and disclosures of my protected health information that will occur in my care, payment of my bills and/or in the performance of health care operations of Spine Align Chiropractic and Scoresby Chiropractic Center. It describes my rights as they concern the limited use of health information, including my demographic information, collected from me and created or received by my physician. The Notice of Privacy Practice for Spine Align Chiropractic and Scoresby Chiropractic Center is available at the main administrative desk of this practice. Spine Align Chiropractic and Scoresby Chiropractic Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practice. I may obtain a revised notice of privacy practices by calling the office and requesting a copy.

This notice is effective as of January 1, 2014

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Patient's Name (print)

____

Patient's Signature Date

____

Office Personnel/Witness Date

WE ARE HERE TO SERVE YOU AND YOUR FAMILY.
WE ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP ENSURE YOUR FAMILY'S RESULTS.

The doctor of the future will give no medicine, but will interest her or his patient in the care of the human frame, in a proper diet, and in the cause and prevention of disease.

Thomas A. Edison
U.S. Inventor (1847-1931)

Patient Health Questionnaire

ChiroCare of Wisconsin, Inc.

ChiroCare Use Only rev 4/19/99

Patient Name ______________________ *Date* ______________

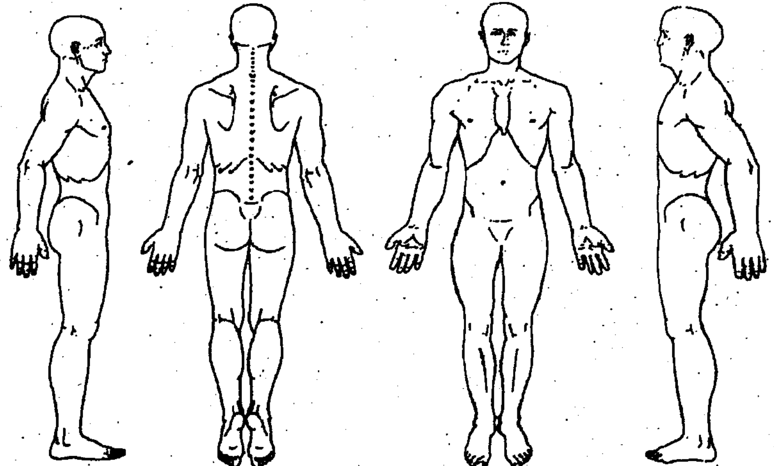
1. When did your symptoms start: ______________ *Describe your symptoms and how they began:*

____

____

2. How often do you experience your symptoms?
- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?
- ☐ Sharp ☐ Shooting
- ☐ Dull ache ☐ Burning
- ☐ Numb ☐ Tingling

4. How are your symptoms changing?
- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse

5. How bad are your symptoms at their:

	None										Unbearable
a. worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints		Mild, forgotten with activity		Moderate, interferes with activity		Limiting, prevents full activity		Intense, preoccupied with seeking relief		Severe, no activity possible

7. What activities make your symptoms worse: ______________________

8. What activities make your symptoms better: ______________________

9. Who have you seen for your symptoms? ☐ No One ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other

a. When and what treatment? ______________________

b. What tests have you had for your symptoms and when were they performed? ☐ Xrays *date:* ________ ☐ CT Scan *date:* ________ ☐ MRI *date:* ________ ☐ Other *date:* ________

10. Have you had similar symptoms in the past? ☐ Yes ☐ No

a. If you have received treatment in the past for the same or similar symptoms, who did you see? ☐ This Office ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other

11. What is your occupation? ☐ Professional/Executive ☐ White Collar/Secretarial ☐ Tradesperson ☐ Laborer ☐ Homemaker ☐ FT Student ☐ Retired ☐ Other

____

a. If you are not retired, a homemaker, or a student, what is your current work status? ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Unemployed ☐ Off work ☐ Other

12. What do you hope to get from your visit/treatment (select all that apply):
- ☐ Reduce symptoms
- ☐ Resume/increase activity
- ☐ Explanation of condition/treatment
- ☐ Learn how to take care of this on my own
- ☐ How to prevent this from occurring again
- ☐

Patient Signature ______________________ *Date* ______________

Patient Health Questionnaire - page 2

ChiroCare of Wisconsin, Inc.

ChiroCare Use Only rev 1/20/99

Patient Name ______________________ *Date* __________

What type of regular exercise do you perform? ☐ None ☐ Light ☐ Moderate ☐ Strenuous

What is your height and weight? Height ☐ Feet ☐ Inches Weight ☐☐☐ lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present	Condition
☐	☐	Headaches
☐	☐	Neck Pain
☐	☐	Upper Back Pain
☐	☐	Mid Back Pain
☐	☐	Low Back Pain
☐	☐	Shoulder Pain
☐	☐	Elbow/Upper Arm Pain
☐	☐	Wrist Pain
☐	☐	Hand Pain
☐	☐	Hip/Upper Leg Pain
☐	☐	Knee/Lower Leg Pain
☐	☐	Ankle/Foot Pain
☐	☐	Jaw Pain
☐	☐	Joint Swelling/Stiffness
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	General Fatigue
☐	☐	Muscular Incoordination
☐	☐	Visual Disturbances
☐	☐	Dizziness

Past	Present	Condition
☐	☐	High Blood Pressure
☐	☐	Heart Attack
☐	☐	Chest Pains
☐	☐	Stroke
☐	☐	Angina
☐	☐	Kidney Stones
☐	☐	Kidney Disorders
☐	☐	Bladder Infection
☐	☐	Painful Urination
☐	☐	Loss of Bladder Control
☐	☐	Prostate Problems
☐	☐	Abnormal Weight Gain/Loss
☐	☐	Loss of Appetite
☐	☐	Abdominal Pain
☐	☐	Ulcer
☐	☐	Hepatitis
☐	☐	Liver/Gall Bladder Disorder
☐	☐	Cancer
☐	☐	Tumor
☐	☐	Asthma
☐	☐	Chronic Sinusitis

Past	Present	Condition
☐	☐	Diabetes
☐	☐	Excessive Thirst
☐	☐	Frequent Urination
☐	☐	Smoking/Use Tobacco Products
☐	☐	Drug/Alcohol Dependence
☐	☐	Allergies
☐	☐	Depression
☐	☐	Systemic Lupus
☐	☐	Epilepsy
☐	☐	Dermatitis/Eczema/Rash
☐	☐	HIV/AIDS
		Females Only
☐	☐	Birth Control Pills
☐	☐	Hormonal Replacement
☐	☐	Pregnancy
☐	☐	
		Other Health Problems/Issues
☐	☐	
☐	☐	
☐	☐	

Indicate if an immediate family member has had any of the following:

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus ☐ __________

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

__________ __________ __________

__________ __________ __________

List all the surgical procedures you have had and times you have been hospitalized:

__________ __________ __________

__________ __________ __________

Patient Signature ______________________ *Date* __________

Doctor's Additional Comments

____

____

____

Doctors Signature ______________________ *Date* __________