Health Questionnaire

Name: _____Age____ Home Phone #: _____ Work Phone #: _____

Address: _____City: _____ State ____Zip: _____

Occupation: _____# Hours/Week Currently Working:_____

E-mail Address: _____Cell Phone #: _____

Check off any of the following symptoms you have experienced in the past 6 months:

☐ Low Back Pain	☐ Tension Across Top of Shoulders	☐ Tired/Fatigued
☐ Pain between Shoulder Blades	☐ Numbness/Tingling in Arms/Hands	☐ Difficulty Sleeping
☐ Neck Pain	☐ Numbness/Tingling in Legs/Feet	☐ Allergies
☐ Tension/Headaches	☐ Pain in the legs	☐ Digestive Problems
☐ Fibromyalgia	☐ Pain in the feet	☐ Carpal Tunnel

OTHER (explain) _____

Which of the above is the worst? _____

How long have you had it? _____

How often does it occur? _____

What does it feel like ?(describe) _____

What have you done that has helped this problem? _____

What activities would you like to do if this was not a problem? _____

Does this cause you to be:	**Does this affect your work:**	**Does this affect your life:**
☐ Moody	☐ Decision making	☐ Lose patience with spouse/children
☐ Irritable	☐ Poor attitude	☐ Restricted household duties
☐ Interrupt sleep	☐ Decreased productivity	☐ Hinders ability to exercise or sports
☐ Restricted in your daily activities	☐ Exhausted at the end of the day	☐ Interferes with ability to do hobbies or other activities
	☐ Unable to work long hours	

What have you tried to help relieve/get rid of this problem and how much did it help? (circle appropriately)

◆ Medications…Helped: Little Some Much	◆ Exercise…Helped: Little Some Much
◆ Physical Therapy…Helped: Little Some Much	◆ Nutrition…Helped: Little Some Much
◆ Chiropractic…Helped: Little Some Much	◆ Stretching…Helped: Little Some Much

OTHER _____

Location Date: Apt:

I consent to receiving a health screening. I realize that I am not receiving a diagnosis, treatment or prognosis for any condition that I may be experiencing. I acknowledge that I am receiving a demonstration only and agree to hold harmless the therapist and/or clinic from any damage resulting from this demonstration.

Signature: _____ **Date:** ____/____/____

How did you hear about us? _____

Automobile Accident Questionnaire: Client Name _____ DOB_____

Fill in the blank and circle the appropriate answers that apply

Accident Details: How did this accident happen?

_____

_____

Driver of other vehicle: _____ Accident time: _____ am pm Date:_____

Insurance Company: _____Phone number:_____

Policy number:_____ **Claim number:**_____

Name of driver of vehicle in which you were injured (self or other:)_____

Insurance Company:_____ Phone number:_____

Policy number:_____ Claim number:_____

Were you traveling north south east west on _____ (street or highway)

Number of people in vehicle:_____ Police Called? Yes No State: _____ Work Related? Yes No

You were: driver passenger front seat back seat using seat belt other protective device (circle all that apply)

Injuries: Did head strike object? Yes No Knocked unconscious? Yes No How Long? _____

Struck from: behind front left side right side

Immediate pain: Yes No When?_____ Location of Pain:_____

How were you transported?_____ Hospital_____

Any problem in injured area prior to accident: Yes No If yes where?_____

Care: Where were you taken after the accident?_____

Treatment given:_____

Doctor attending_____ Diagnosis_____

Length of care provided_____ Injury resulting in permanent disability? Yes No

Activities: Before injury, capable of working on equal basis with others your age? Yes No

Is work restricted as result of accident?: Yes No Since injury Symptoms getting: better worse same disabled

Patient Signature: _____Date:_____

Lien and Payment Authorization

Lien Notice to : Attorney/Firm _____Phone#_____

Address_____

Dr. David Gulledge D.C. M.S. FASA Dr. Kyle Gulledge D.C. CSCS FASA
Dr. Shirin Moshiri Gulledge D.C

Lien in Favor of Gulledge Family Wellness LLC, Dr. Shirin P.A.

Address: 11879 W. 112th Street STE 100/Overland Park, KS 66210

To Attorney:

1. I have Requested and Gulledge Family Wellness (GFW LLC/Dr. Shirin PA) has agreed to render medical care/treatment to me for injuries I sustained in the accident which occurred on (date)_____ City of _____ State___ Including: examination, diagnosis, treatment and prognosis of myself in regard to my accident.
2. I hereby give an IRREVOCABLE LIEN in favor of said GFW LLC/Dr. Shirin PA on any settlement claim judgment or verdict as a result of said accident.
3. If my Attorney receives any proceeds from any Insurance Company for medical services rendered me by GFW LLC/Dr. Shirin PA, I request and authorize such payment to be forwarded to GFW LLC /Dr. Shirin P.A.
4. If I receive any payments from Insurance Company for medical services rendered from GFW LLC/Dr. Shirin P.A. I will promptly deliver all such payments to GFW LLC/Dr. Shirin P.A. If I fail to do so, the net balance is immediately due and payable to GFW LLC/Dr. Shirin PA.
5. I fully understand that I am personally responsible to GFW LLC/Dr. Shirin PA. for all the bills submitted by GFW LLC/Dr. Shirin PA for services rendered me and that this agreement is made solely for said medical facilities additional protection from insurance Company for medical services rendered me by GFW LLC/Dr. Shirin PA.
6. I understand that my responsibility of payment for medical services rendered by GFW LLC/Dr. Shirin P.A. is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover.
7. I hereby waive signature, in favor of GFW LLC/Dr. Shirin PA on any check paid by said insurance.
8. I agree that a copy of this agreement is as valid and binding as the original
9. I agree for GFW LLC/Dr Shirin PA to be paid in full before disbursement of monies to me.
10. I agree for this lien to be binding on any subsequent Legal Representative.

Client Name: _____ SSN# _____ File #_____

Address:_____Phone:_____

Signature _____ Witness_____

Attorney: The undersigned, being attorney of record and/or authorized representative of the above client, does hereby acknowledge receipt of the above client's request and lien, and agrees to comply with client's request regarding fees, only from monies received for client's account , for medical treatments and services rendered to the above client. I am personally responsible ONLY for any 'reports' or 'copies of records' that I may request.

Attorney Name: (print) _____ Attorney Signature: _____

Dated:_____ Please sign, copy and return in the envelope provided. Thank you.

Date Sent to Attorney:_____ Date Received from Attorney:_____

WELCOME

Date: _____

Patient Information

Name: _____
Last First MI

Email address: _____

Mailing Address: _____ City _____ State _____ Zip _____

Phone # (H)_____ (W) _____ (Other) _____

Can we call you at work? ❑ Yes ❑ No

Date of Birth: _____ Sex: ❑ Male ❑ Female **SS#:** _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other ____

Ethnicity ❑ Hispanic ❑ Latino ❑ Non-Hispanic / Non-Latino

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Phone #: (H) _____ (W) _____

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other _____

Has it been reported? ❑ Yes ❑ No If yes, to whom? _____

Insurance Information

Policy Holder Name: _____ D.O.B. :_____

Relationship to patient (if other than self): _____ Phone # _____

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____ **DATE** _____

Health History

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

❑ Neck Pain/Stiffness	❑ Pins/Needles in Arms	❑ Light Bothers Eyes	❑ Sudden Weight Loss	❑ Nausea
❑ Back Pain/Stiffness	❑ Pins/Needles in Legs	❑ Depression	❑ Loss of Taste	❑ Cold Feet
❑ Arm/Hand Pain	❑ Fatigue	❑ Nervousness	❑ Loss of Memory	❑ Chest Pain
❑ Leg/Knee Pain	❑ Sleeping Difficulties	❑ Tension	❑ Jaw Problems	❑ Fever
❑ Headaches	❑ Loss of Smell	❑ Cold Sweats	❑ Constipation	❑ Fainting
❑ Dizziness	❑ Allergies	❑ Stomach Problems	❑ Shortness of Breath	
❑ Asthma	❑ Blurred Vision	❑ Night Pain	❑ Bowel/Bladder Changes	

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV	❑ Cancer	❑ Hepatitis	❑ Osteoporosis	❑ Stroke
❑ Alcoholism	❑ Cataracts	❑ Hernia	❑ Pacemaker	❑ Suicide Attempt
❑ Allergy Shots	❑ Chemical Dependency	❑ Herniated Disc	❑ Parkinson's Disease	❑ Thyroid Problems
❑ Anemia	❑ Chicken Pox	❑ Herpes	❑ Pinched Nerve	❑ Tonsillitis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tuberculosis
❑ Appendicitis	❑ Emphysema	❑ Kidney Disease	❑ Polio	❑ Tumors/Growths
❑ Arthritis	❑ Epilepsy	❑ Liver Disease	❑ Prostate Problems	❑ Typhoid Fever
❑ Asthma	❑ Fractures	❑ Measles	❑ Prosthesis	❑ Ulcers
❑ Bleeding Disorders	❑ Glaucoma	❑ Migraines	❑ Psychiatric Care	❑ Vaginal Infections
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Venereal Disease
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Rheumatic Fever	❑ Whooping Cough
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis	❑ Scarlet Fever	
	❑ Heart Disease	❑ Mumps	❑ Other _____	

Are you currently under drug and/or medical care? ❑ Yes ❑ No If yes, explain _____

Please list any medications you are currently taking (**Be sure to include dosage and frequency**)_____

_____

Please list any surgeries and/or hospitalizations you have had (**type & date**): _____

_____

_____

Please list any allergies: _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (**Indicate family member including parents, grandparents & siblings**)

❑ Heart Disease _____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Do you exercise: ❑Never ❑Daily ❑ Weekly ❑Walks ❑Runs ❑Swims

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ **DATE** _____

NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE

NAME _____ **DATE** _____

For any YES answer, please include details.

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment: _____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment: _____
3. Do your hands or arms fall asleep regularly? NO YES
   Comment: _____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment: _____
5. Do you suffer from a loss of handgrip strength? NO YES
   Comment: _____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment: _____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: _____
8. Do our legs or feet fall asleep regularly? NO YES
   Comment: _____
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
   Comment: _____
10. Do you suffer from cold hands or feet? NO YES
    Comment: _____
11. Do have frequent falls or find that you trip over your feet while walking? NO YES
    Comment: _____
12. Do you suffer from headaches? If yes, how often, how severe, what has been tried? NO YES
    Comment: _____
13. Have you tried any medications such as anti-inflammatory? NO YES
    If yes, what kind of medication?
    _____
14. Have you tried any Physical Therapy or Chiropractic treatments before? NO YES
    If yes: When? For how long? What kind?
    _____
15. Have you had an MRI? NO YES
    If yes: When? Who ordered it? What was it ordered for?
    _____
16. Have you used any splint or braces or other prescribed treatment by an MD? NO YES
    If yes: When? What kind? Who ordered it?
    _____
17. If you have tried any treatment or medications, did this make your problem better? NO YES
    Comment: _____

ALLERGIES: (Please place a check mark next to any known allergy that you have.)

___ Milk ___Eggs ___Peanuts ___Almonds ___Cashews ___Walnuts ___ Fish ___ Shellfish ___Soy ___Wheat
___ Gluten ___Penicillin ___Sulfa Drugs ___Tetracycline ___Codeine ___NSAIDS ___Phenytoin ___Carbamazepine
___Mildew ___Mold ___ Dust ___Fungus ___Mites ___Tree Pollen ___Grass Pollen ___Weed Pollen ___Insects ___Dog Dander ___Cat Dander ___Latex ___Other Animal Dander ___ OTHER: _____ *(please fill in)*

Allergy, Food & Chemical Sensitivity Survey

Gender: M / F Height: Feet _____Inches _____ Weight: _____lbs.

Please complete the following allergy, food and chemical sensitivity questionnaire. Score each symptom based upon your experiences over the last 90 days. Circle appropriate number 0-5 according to severity.

0=No Problem at All
1=Extremely Mild Symptoms
2=Mild to Moderate Symptoms Occasionally
3=Moderate Symptoms Frequently
4=Moderate to Severe Symptoms
5=Very Severe Symptoms

Digestive Symptoms
0 1 2 3 4 5 Stomach Pains or Cramping
0 1 2 3 4 5 Constipation
0 1 2 3 4 5 Diarrhea
0 1 2 3 4 5 Reflux or Heartburn
0 1 2 3 4 5 Bloating
0 1 2 3 4 5 Gas
0 1 2 3 4 5 Nausea or Vomiting

Weight
0 1 2 3 4 5 Inability to Lose Weight
0 1 2 3 4 5 Food Cravings
0 1 2 3 4 5 Binge Eating
0 1 2 3 4 5 Water Retention

Sinus/Respiratory
0 1 2 3 4 5 Stuffy or Runny Nose
0 1 2 3 4 5 Asthma
0 1 2 3 4 5 Chest Congestion
0 1 2 3 4 5 Chronic Cough
0 1 2 3 4 5 Wheezing
0 1 2 3 4 5 Frequent Sneezing or Nasal Discharge

Head/Ears
0 1 2 3 4 5 Migraines
0 1 2 3 4 5 Headaches
0 1 2 3 4 5 Earaches
0 1 2 3 4 5 Sinus or Ear Infections
0 1 2 3 4 5 Ringing in Ears

Eyes/Throat
0 1 2 3 4 5 Itchy Eyes
0 1 2 3 4 5 Watery Eyes
0 1 2 3 4 5 Sore Throats or Colds
0 1 2 3 4 5 Persistent Canker Sores

Emotional/Mental
0 1 2 3 4 5 Depression
0 1 2 3 4 5 Anxiety
0 1 2 3 4 5 Mood Swings
0 1 2 3 4 5 Irritability
0 1 2 3 4 5 Poor Concentration/Memory

Energy
0 1 2 3 4 5 Fatigue
0 1 2 3 4 5 Hyperactivity
0 1 2 3 4 5 Lethargy
0 1 2 3 4 5 Restlessness
0 1 2 3 4 5 Insomnia

Skin Disorders
0 1 2 3 4 5 Eczema
0 1 2 3 4 5 Dermatitis
0 1 2 3 4 5 Excessive Sweating
0 1 2 3 4 5 Rashes
0 1 2 3 4 5 Hives

Other Symptoms:
0 1 2 3 4 5 Joint Pain
0 1 2 3 4 5 Arthritis
0 1 2 3 4 5 Irregular Heartbeat
0 1 2 3 4 5 Chest Pains
0 1 2 3 4 5 Muscle Aches

Please list any symptoms not mentioned above:
_____
_____

TOTAL SCORE: _____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

The patient is aware and understands that the Health Professionals that work for Elite Physical Medicine, PA, may also work at an outside facilities or hospital. The patient releases and waives all liability for any professional, entity, or facility outside of Elite Physical Medicine, PA.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

_____ _____

Patient's Signature Date

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies needed. In addition, they will help us determine if there is any reason to modify your care of provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I understand and accept that there are risks associated with chiropractic care and give consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

This notice is effective as of the date it is signed and will expire seven years after the date on which you last received services from us.

_____

Patient Signature Date

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

☐ There is a possibility that I a may be pregnant at this time.

☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time

☐ I request that x-ray films not be taken because: _____

_____

_____

Date of last menstrual period: _____

_____ _____

Patient's Signature Date

Financial and Insurance Policy

We will try to assist patients in obtaining insurance benefits whenever possible. It must be understood, however that:

1. The patient is responsible for full payment of all services rendered on their behalf or on behalf of their dependent.

2. We will call to verify benefits. **However, we cannot be responsible for errors in the quoting of benefits.** We suggest that you become aware of your own benefits, deductibles, and maximums, etc.

3. **Insurance is a contract between you, the Insurance Company and/or your employer.** We are not a party to that contract. Assisting you in trying to obtain payment is a courtesy and may be withdrawn at any time.

4. Other insurance carriers are billed weekly by us. Insurance payments are generally received within 30 days. The maximum time limit that we extends is 60 days. Thereafter the patient must pay the fees in full.

5. If the patient discontinues care for any reason other than discharge by the doctor, the patient must pay the outstanding balance in full, immediately – regardless of any claims submitted.

6. If the patient fails to keep regular appointments, they will be discharged. The patient must pay the outstanding balance in full, immediately.

7. If the patient fails to pay off the balance due or make consistent payments, the account will be turned over for collection after 45 days of no payment. The patient will also be responsible for any collection fees acquired in the collection process.

8. Any refunds made to patients will be based on the full account balance, without presuming further insurance benefits that may be payable.

9. If there is any balance due after the Statement of Benefits is received from the insurance carrier, that balance is due from the patient immediately.

I have read and I agree to the above. Further, I hereby authorize and request that insurance companies pay directly to us, any insurance benefits for chiropractic care, health related service and durable medical equipment that would otherwise be payable to me.

_____ _____

Name Date

Missed Appointment Policy

If you cannot be at the office at your regularly scheduled appointment time, please give 24 hours notice. **If 24 hour notice is not given for a missed appointment, an office visit fee of $40 will be charged to your credit card on file.**

_____ _____

Name **Signature**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB: _____

I acknowledge that I have reviewed the Notice of Privacy Practices of Gulledge Family Wellness/Elite Physical Medicine.
(Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

_____ I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Witness (Office Staff) Date

A. Notifier: Gulledge Family Wellness

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Exam Fees **Xrays at this office** **Extremity adjustments**	*Medicare does not pay for this test for your condition. *Medicare does not pay for this test as often as this (denied as too frequent). *Medicare does not pay for experimental or research use tests.	*For a service that costs "Between $40 – $499," or "No more than $500."

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: