Decatur Back & Neck Center, PC

Confidential Health History

Name: _____ **Home Phone:** _____

Address: _____ **Cell Phone:** _____

City: _____ **State:** _____ **Date of Birth:** _____

Zip Code: _____ **Sex:** M or F **Other**_____

Marital Status: M S W D

Employer: _____ **Work Location:** _____

Occupation: _____ **Work Phone:** _____

Email:

_____

Please describe your health problem: _____

_____

_____

List any other doctors seen for this problem:

_____

_____

List any diagnosis and/or treatments: _____

_____

_____

List any unusual diseases and year or occurrence/diagnosis:

_____

_____

Have you been treated for any health condition in the past year?

_____

_____

Have you received chiropractic treatment previously? If yes, explain:

_____

_____

We greatly appreciate referrals to our office. So we may thank them, who referred you to our office or how did you hear of our office?

_____

Please check the condition(s) you are now having and those you frequently have.

MUSCULO-SKELETAL SYSTEM
___ Low back problems
___ Pain between shoulders
___ Neck problems
___ Arm problems
___ Leg problems
___ Swollen joints
___ Painful joints
___ Stiff joints
___ Sore muscles
___ Weak muscles
___ Walking problems
___ Ruptures
___ Broken Bones

GENITO-URINARY SYSTEM
___ Bladder trouble
___ Excessive urine
___ Scenty urination
___ Painful urination
___ Discolored urine

FEMALE
___ Vaginal discharge
___ Vaginal bleeding
___ Vaginal pain
___ Breast pain
___ Lumps on breast

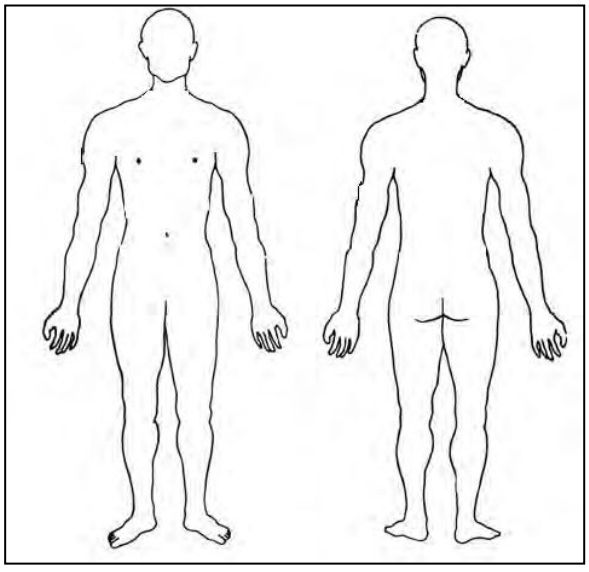
ARE YOU PREGNANT
___ Yes ___ No

GASTRO-INTESTINAL SYSTEM
___ Poor Appetite
___ Excessive hunger
___ Difficulty chewing
___ Difficulty swallowing
___ Excessive thirst
___ Nausea
___ Vomiting food
___ Vomiting blood
___ Abdominal pain
___ Diarrhea
___ Constipation
___ Black stool
___ Bloody stool
___ Hemorrhoids
___ Liver trouble
___ Gall bladder problems
___ Weight trouble

NERVOUS SYSTEM
___ Numbness
___ Loss of feeling
___ Paralysis
___ Dizziness
___ Fainting
___ Headaches
___ Muscle jerking
___ Convulsions
___ Forgetfulness
___ Confusion
___ Depression

CARDIOVASCULAR-RESPITORY
___ Chest pain
___ Pain over heart
___ Difficulty breathing
___ Persistent cough
___ Coughing phlegm
___ Coughing blood
___ Rapid heartbeat
___ Blood pressure problems
___ Heart problems
___ Lung problems
___ Varicose veins

EYE, EAR, NOSE AND THROAT
___ Eye strain
___ Eye inflammation
___ Vision problems
___ Ear pain
___ Ear noises
___ Hearing loss
___ Ear discharge
___ Nose pain
___ Nose bleeding
___ Nose discharge
___ Difficulty breathing through nose
___ Sore gums
___ Dental problems
___ Sore mouth
___ Sore throat
___ Hoarseness
___ Difficulty with speech



Please mark your areas of pain on the figures to left.

In case of emergency, please notify:
Name:

Address:

Phone:

Signature: _____

Decatur Back & Neck Center, PC

In accordance with the Patient Affordable Care Act of 2010, we are updating our records. Thank you for your cooperation.

Name _____ Home Phone_____

Address _____ Cell Phone _____

City _____ State _____ Zip Code _____ Sex: M or F, Other _____

Occupation _____ Date of Birth _____

Employer _____ Right handed or Left handed (circle)

Family History	Diseases in the Family? (Arthritis, Heart Disease, Cancer, Diabetes, Multiple Sclerosis?)	Living or deceased?
Mother		
Father		
Brothers		
Sisters		
Grandmother(s)		
Grandfather(s)		

Please list ALL surgeries	Year of Surgery

Please List any allergies to food, medication and other factors

Smoking Status:
Please check one:
____ Never a smoker

____Current every day smoker_____ packs per day_____

____ Current periodic smoker. How often _____

____ Former Smoker. Quit in _____ year.

How many Children do you have? _____

Do you drink alcohol? _____ drinks per day/month (please circle)

Caffeine? How often? _____ How much? _____
What kind of caffeine (circle)? Coffee ____Soda _____ Tea_____ Other_____

Current Medications	**Dosage**

Signature _____

Date _____

Decatur Back & Neck Center

Physical Activity Readiness Questionnaire (PAR-Q)

Patient Name (Print) _____ **Signature** _____

Date _____

1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
   _____Yes
   _____No

2. Do you feel pain in your chest when you do physical activity?
   _____Yes
   _____No

3. In the past month, have you had chest pain when you were not doing physical activity?
   _____Yes
   _____No

4. Do you lose your balance because of dizziness or do you ever lose consciousness?
   _____Yes
   _____No

5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
   _____Yes
   _____No

6. Is your medical doctor currently prescribing drugs (for example water pills) for your blood pressure or heart condition?
   _____Yes
   _____No

7. Do you know of any other reason why you should not do physical activity?
   _____Yes
   _____No

Revised Oswestry Low/Mid Back Pain Disability Questionnaire

Instructions: This questionnaire is designed to enable us to understand how much your **lower and/or mid back** pain has affected your ability to manage your everyday activities. Please answer each section below utilizing the one best answer that most applies to you. We realize that that you may feel that more than one statement may relate to you, but **please just circle the one choice that closely describes your problem right now**.

Patient: _____

Date: _____

1. 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 severe.
5) The pain is severe and does not vary much.

2. Personal Care
0) I would 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 or dressing without help.

3. 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, but I can manage light to medium weights if they are conveniently positioned.
5) I can only lift very light weights, at the most.

4. Walking
0) Pain does not prevent me from walking any distance.
1) Pain prevents me from walking more than one mile.
2) Pain prevents me from walking more than one-half mile.
3) Pain prevents me from walking more than one-quarter mile.
4) I can only walk while using a cane or on crutches.
5) I am in bed most of the time and have to crawl to the toilet.

5. Sitting
0) I can sit in a chair as long as I like without pain.
1) I can only sit in my favorite chair as long as I like.
2) Pain prevents me from sitting more than one hour.
3) Pain prevents me from sitting for more than one-half hour.
4) Pain prevents me from sitting for more than ten minutes.
5) Pain prevents me from sitting at all.

6. Standing
0) I can stand as long as I like without pain.
1) I have some pain while standing, but it does not increase with time.
2) I cannot stand for longer than one hour without increasing pain.
3) I cannot stand for more than one-half hour without increasing pain.
4) I cannot stand for longer than ten minutes without increasing pain.
5) I avoid standing, because it increases the pain straight away.

7. 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 my pain, my normal night's sleep is reduced by less than one-quarter (1/4).
3) Because of my pain, my normal night's sleep is reduced by less than one-half (1/2).
4) Because of my pain, my normal night's sleep is reduced by less than three-quarters (3/4).
5) Pain prevents me from sleeping at all.

8. Social Life
0) My social life is normal and gives me no pain.
1) My social life is normal but increases the degree of my pain.
2) Pain has no effect 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.

9. Traveling/Car Travel/Driving
0) I get no pain while traveling.
1) I get some pain while traveling, but none of my usual forms of travel make it any worse.
2) I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
3) I get extra pain from traveling which compels me to seek alternative forms of travel.
4) Pain restricts all forms of travel.
5) Pain prevents all forms of travel except that are done lying down.

10. 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 at present.
3) My pain is neither getting better or worse.
4) My pain is gradually worsening.
5) My pain is rapidly worsening.

Score: _____
office use only

Patient Signature:

_____

Neck Pain Disability Index Questionnaire

Instructions: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section below utilizing the **one** best answer that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just circle the one choice that closely describes your problem right now.**

Patient: _____

Date: _____

1. Pain Intensity

0) I have no pain at the moment.
1) The pain is very mild at the moment.
2) The pain is moderate at the moment.
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.

2. Personal Care

0) I can look after myself normally without causing extra pain.
1) I can look after myself, 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 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.

3. Lifting

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

4. Reading

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

5. 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.

6. Concentration

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

7. Work

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

8. Driving

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

9. 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).

10. Recreation

0) I am able to engage in all of my recreational activities with no neck pain at all.
1) I am able to engage in all of my recreational activities with some pain in my neck.
2) I am able to engage in most, but not all of my recreational activities because of pain in my neck.
3) I am able to engage in a few of my usual recreational activities because of pain in my neck.
4) I can hardly do any recreational activities because of pain in my neck.
5) I cannot do any recreational activities at all.

Patient Signature:

_____

Score: _____

office use only

Patient Name: _____**Date**: _____

Please CHECK the correct response:

1. **I have headaches**: ____ 1 per month _____ More than 1 but less than 4 per month _____ More than 1 per week

2. **My headaches are:** _____ Mild _____ Moderate _____ Severe

Instructions: (please read carefully): The purpose of this scale is to identify difficulties that you may be experiencing because of your headache. Please CIRCLE "YES," SOMETIMES," or "NO" to each item. Answer each question as it pertains to your headache only.

E1	Because of my headaches I feel handicapped.	Yes	Sometimes	No
F2	Because of my headaches I feel restricted in performing my routine daily activities.	Yes	Sometimes	No
E3	No one understands the effect my headaches have on my life.	Yes	Sometimes	No
F4	I restrict my recreational activities (eg, sports, hobbies) because of my headaches.	Yes	Sometimes	No
E5	My headaches make me angry.	Yes	Sometimes	No
E6	I feel that I am going to lose control because of my headaches.	Yes	Sometimes	No
F7	Because of my headaches I am less likely to socialize.	Yes	Sometimes	No
E8	My spouse (or significant other), or family and friends have no idea what I am going through because of my headaches.	Yes	Sometimes	No
E9	My headaches are so bad that I feel I am going to go insane.	Yes	Sometimes	No
E10	My outlook on the world is affected by my headaches.	Yes	Sometimes	No
E11	I am afraid to go outside when I feel a headache is starting.	Yes	Sometimes	No
E12	I feel desperate because of my headaches.	Yes	Sometimes	No
F13	I am concerned that I am paying penalties at work or at home because of my headaches.	Yes	Sometimes	No
E14	My headaches place stress on my relationships with family or friends.	Yes	Sometimes	No
F15	I avoid being around people when I have a headache.	Yes	Sometimes	No
F16	I believe my headaches are making it difficult for me to achieve my goals in life.	Yes	Sometimes	No
F17	I am unable to think clearly because of my headache.	Yes	Sometimes	No
F18	I get tense (eg, muscle tension) because of my headaches.	Yes	Sometimes	No
F19	I do not enjoy social gatherings because of my headaches.	Yes	Sometimes	No
E20	I feel irritable because of my headaches.	Yes	Sometimes	No
F21	I avoid traveling because of my headaches.	Yes	Sometimes	No
E22	My headaches make me feel confused.	Yes	Sometimes	No
E23	My headaches make me feel frustrated.	Yes	Sometimes	No
F24	I find it difficult to read because of my headaches.	Yes	Sometimes	No
F25	I find it difficult to focus my attention away from my headaches and on other things.	Yes	Sometimes	No

Disabilities of the Arm, Shoulder and Hand

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry a heavy object (over 10 lbs.).	1	2	3	4	5
12. Change a lightbulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	1	2	3	4	5
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another).	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5

Disabilities of the Arm, Shoulder and Hand

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
22. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors, or groups? *(circle number)*	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? *(circle number)*	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*

	NONE	MILD	MODERATE	SEVERE	EXTREME
24. Arm, shoulder or hand pain.	1	2	3	4	5
25. Arm, shoulder or hand pain when you performed any specific activity.	I	2	3	4	5
26. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27. Weakness in your arm, shoulder or hand.	I	2	3	4	5
28. Stiffness in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

	STRONGLY DISAGREE	DISAGRE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. *(circle number)*	1	2	3	4	5

DASH DISABILITY/SYMPTOM SCORE = $\left[\left(\frac{\text{sum of n responses}}{n}\right) - 1\right] \times 25$, where n is equal to the number of completed responses.

A DASH score may <u>not</u> be calculated if there are greater than 3 missing items.

LOWER EXTREMITY FUNCTIONAL SCALE

Name: _____ Date: _____

Please rate your ability to do the following activities **if you had to do them today**. Circle the appropriate response. Circle only ONE response per activity.

Activity	Extreme Difficulty or Unable	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
Any of your usual work, housework, or school activities.	0	1	2	3	4
Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
Getting in or out of a bath.	0	1	2	3	4
Walking between rooms.	0	1	2	3	4
Putting on your shoes or socks.	0	1	2	3	4
Squatting	0	1	2	3	4
Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
Performing light activities around your home.	0	1	2	3	4
Performing heavy activities around your home.	0	1	2	3	4
Getting into or out of a car.	0	1	2	3	4
Walking two blocks.	0	1	2	3	4
Walking a mile.	0	1	2	3	4
Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
Standing for one hour.	0	1	2	3	4
Sitting for one hour.	0	1	2	3	4
Running on **even** ground.	0	1	2	3	4
Running on **uneven** ground.	0	1	2	3	4
Making sharp turns while running fast.	0	1	2	3	4
Hopping.	0	1	2	3	4
Rolling over in bed.	0	1	2	3	4

Office Use Only: LEFS _____/80

Decatur Back and Neck Center, PC
Informed Consent

Please read this entire document prior to signing. Ask questions before you sign if there is anything that is unclear.

Based on my complaints and the history I have provided, I hereby authorize Decatur Back and Neck Center ("the Practice") and its licensed doctors and assistants to undertake an examination and provide an evaluation and treatment plan that may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate. I understand that state law entitles me to receive information concerning my condition and proposed treatment and refuse any treatment to the extent permitted by law. With that knowledge and with my consent, I wish to rely on the Decatur Back and Neck Center doctors to make those decisions about my care based on the facts they believe are in my best interest.

As a part of the analysis, examination, and treatment, I am consenting to services that may include: Chiropractic adjustment, palpation, massage therapy, spinal decompression, intersegmental traction, vital signs, range of motion testing, orthopedic testing, neurological testing, muscle strength testing, postural analysis testing, hot/cold therapy, EMS, radiographic studies and other procedures as necessary. The nature and purpose of the chiropractic examination and evaluation, the chiropractic adjustments, and the other procedures that may be recommended during the course of my care have been explained and described to my satisfaction.

Based on current findings, I understand that the Practice doctors will discuss my diagnosis and treatment plan, the benefits and expected improvement with the proposed treatment, and the reasonable alternatives to the proposed treatment. They will also explain the cost of my proposed care (or provide me with a current fee schedule).

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those that relate to physical aberrations unknown or reasonably undetectable by the doctor. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if I have a condition that would otherwise not come to the Doctor's attention, I understand that it is my responsibility to inform the Doctor before treatment.

The availability and nature of other treatment options may include self-administered, over-the-counter analgesics and rest, medical care, and drugs such as anti-inflammatories, muscle relaxants, painkillers, hospitalization, or surgery. If one chooses to use one of the above-noted "other treatment" options, one should be aware of the risks and benefits of such options, and I understand that I may wish to discuss these with my primary medical physician.

The risks and dangers of remaining untreated:

Remaining untreated may allow the formation of adhesions and reduce mobility, setting up a pain reaction and further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

This document is intended as a general, broad-based consent that applies to all contemplated procedures. I have discussed all of the above risks and benefits with the practice, and, if applicable, have made an informed decision that the potential benefits outweigh the risks in my case.

I understand and accept that:

1. l have the right to withdraw from or discontinue any treatment at any time, and the Practice doctors will advise me of any material risks in this regard.
2. Neither the practice of chiropractic nor medicine is an exact science, and my care may involve making judgments based on the facts known to the doctor during my care.
3. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.
4. The practice does not guarantee results concerning any course of care or treatment.
5. My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent.

I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand the care and treatment l may receive to my satisfaction. My signature below acknowledges my consent to the practice's examination, evaluation, and proposed course of care and treatments.

_____ _____

Witness Patient's Printed Name

_____

Patient's Signature

_____

Signature of Doctor

Patient Consent to Telehealth Services

Please read carefully. If you have any questions, please get in touch with a staff member. Telehealth services involve using electronic communications to enable healthcare providers to deliver healthcare services to patients using interactive video and audio communications. This document outlines the potential benefits and risks associated with Telehealth services and confirms your consent to the use of Telehealth services in your health care.

I, _____ (PRINT), understand the following:

1. I have the right to withhold or withdraw my consent to the use of Telehealth at any time without affecting my right to future care or treatment.
2. There are limitations, risks, benefits, and consequences associated with Telehealth, including but not limited to disruption of transmission by technology failures, interruption and breaches of confidentiality by unauthorized persons, or limited ability to respond to emergencies. The laws protecting my personal information's confidentiality also apply to Telehealth.
3. The same standard of care that would apply to an in-person visit also applies to Telehealth. I am responsible for ensuring my privacy at home and being considerate of disruptions and recording devices. I am responsible for the privacy and security of my email inbox and others who might have access to it.
4. There will be no video or audio recording of any session by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization.
5. My healthcare information may be shared with others within our office for scheduling and billing purposes.
6. Certain technical failures may necessitate rescheduling my appointment or continuing my visit by alternative means.
7. If applicable, I am responsible for any out-of-pocket costs, such as copayments or coinsurance, that may apply to my Telehealth visit. I understand that health plan payment policies for Telehealth visits may differ from those for in-person visits. I understand that I am responsible for payment if my insurance does not cover my Telehealth visits.
8. This document will become part of my permanent health record.

I give my informed consent for using Telehealth services in my health care as applicable. I have personally read this form (or had it explained to me) and fully understand and agree to its contents. My questions about Telehealth services have been answered to my satisfaction, and the risk, benefits, and alternatives to Telehealth services have been shared with me in a language I understand.

I am located in the state of _____and will remain in this state, during my Telehealth encounter(s).

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature (if applicable) Date

_____ _____
Witness Signature Date

DECATUR BACK AND NECK CENTER

For use and/or disclosure of Protected Health Information (PHI)
To carry out Treatment, Payment, and Healthcare Operations

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Privacy Notice was provided to me before I signed this consent. It explains how my protected health information ("PHI") may be used and disclosed as needed for this office to provide treatment, bill for services, and carry out healthcare operations. The office has told me that I can request a copy of the Privacy Notice at any time. They also explained my right to get a copy of the Privacy Notice before signing this consent and encouraged me to read it carefully.
2. Our office reserves the right to modify its privacy practices as described in its Privacy Notice in accordance with applicable law.
3. The "Notice of Privacy Practices" is also available in the front lobby. I may also request a copy from this office at any time by US Mail or email.
4. This Notice of Privacy Practices also explains my rights and the responsibilities of this office regarding my protected health information.
5. Our office may communicate with our providers and staff regarding your treatment, billing, and audit procedures.
6. This acknowledgment serves as consent for all future uses or disclosures related to treatment, payment, and health care operations. You may request at any time that we limit the use or disclosure of your health information or specify that certain information not be used or disclosed for treatment, payment, or health care purposes after you have given your consent for those purposes.

I have read and understood the preceding notice, and all my questions have been answered to my complete satisfaction in a way that I can understand.

_____
_____
Name of Individual (Printed) Signature of Individual

_____
_____
Signature of Parent/Guardian Date Signed

Witness: _____

More information and signature needed on the back of the form!

Information about you, your appointment time or your examination results cannot be disclosed to persons other than you, unless you authorize us to do so. If you wish us to disclose information to persons other than you, please indicate who they are below.

NAME	Relationship	Telephone Number

Signature: _____

Date: _____

Decatur Back & Neck Center, PC
OFFICE FINANCIAL POLICY

It is our policy that following a preliminary exam, any services which are rendered by this office on the initial visit shall be paid for at that time, unless other arrangements have been made in writing. Our office is pleased to accept your insurance assignment, as soon as your exact coverage is verified by the responsible party. However, it must be fully understood that the contract is between you and your insurance company, and you are fully responsible for all amounts not paid by your insurance.

Our office policy is as follows:

1. Since by taking your insurance assignment, we must await payment, this courtesy may be withdrawn if warranted.
2. The deductible amount must be paid in full prior to billing.
3. Insurance payments should be made every 30 days. the maximum time limit we extend is 60 days, then fees must be paid in full by the patient.
4. You are required to sign "Authorization to Pay Physician" form and any other documents required by your insurance company.
5. Our office **will not** guarantee that your insurance company will pay. At the beginning of your healthcare, we will make every attempt to receive verification of your policy coverage. However, if for any reason your claim is denied, you are responsible for the total amount due this office.
6. This office will not enter a dispute with your insurance company over your claim. This is your responsibility and obligation. We will, however, assist you in any way that we can.
7. You the patient must keep current with your insurance co-payment.
8. A 1.5% finance charge will be added to all accounts over 90 days old.
9. If your account is past due, it may be turned over to a collection agency. If our account is not paid in full and this account is turned over to a collection agency and/or attorney, then you agree to be responsible for all reasonable fees necessary for the collection agency fees of 50% of the balance due and costs and reasonable attorney's fees of 33% of the balance.
10. You the patient are responsible for any missed appointment fees. Decatur Back and Neck Center reserves the right to charge a missed appointment fee of $31.00 for a Chiropractic visit, and $50.00 rehabilitation visit. A missed appointment fee may be applied if you the patient do not give a 24-hour notice to our office.
11. If the insurance company sends you payment for our services, it is your responsibility and obligation to bring to us payment in full.
12. You are required to inform our office if your insurance coverage changes. If you the patient terminate your Chirohealth insurance policy, you will be responsible for the full fee and responsible for the total amount due.

I have fully read, and agree to this financial policy as written:

Signed: _____

Date: _____

Witness: _____

Decatur Back & Neck Center Employee Signature

Decatur Back and Neck Center, 3350 N. Water St, Ste A, Decatur, IL 62526 217-877-2404

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

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for the services 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 services below.

Services.	Reason Medicare May Not Pay:	Estimated Cost
Spinal Manipulation	Medicare does not pay for maintenance care. Your care may be construed to be maintenance care	98940 $25.65 98941 $37.28 98942 $48.31

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 services 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 services 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 services 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 services 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 may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Decatur Back and Neck Center
Peter W. Vercellino, DC
3350 North Water Street
Decatur, IL 62526 217-877-2404

NOTICE OF NON-COVERAGE

NOTE: Medicare does not cover the following services in the Chiropractic office. In Medicare, coverage is only for spinal manipulation. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. Medicare may not pay for the services listed below.

Services	Estimated Cost
Examination	$80 - $285
X-rays	$80 - $210
Non-Spinal Manipulation	$44
Therapy such as ultrasound, electric stim, interferential, intersegmental traction, and rehabilitation exercises	$12 - $25 per type of therapy. Rehabilitation exercises $48 per unit
Nutrition Supplements, ice packs, pillows, Biofreeze, etc.	Dependent on product. Ask for pricing.

If you have other questions on Medicare coverage, call 1-800-MEDICARE (1-800-633-4227). Signing below means that you have received and understand this notice. You also receive a copy.

Patient Name (PRINT): _____

Signature: _____

Date: _____

Decatur Back and Neck Center, 3350 N. Water St, Suite A, Decatur, Illinois 62526

Authorization to Release Medical Records:

Patient Name (print) **DOB**

INFORMATION TO BE RELEASED FROM:

Name of facility or provider: _____

Address: _____

INFORMATION TO BE SENT TO:

Name of designated recipient: Decatur Back and Neck Center

Address: 3350 N Water Suite A City: Decatur State IL Zip: 62526

PURPOSE OF RELEASE OF INFORMATION: (check one)

_____ Attorney _____Insurance ___X___Doctor _____Personal

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization to allow for these records to be released except the following (if applicable):

*EXCLUDE the following information from the records released (please initial)

_____ Drug / Alcohol abuse/treatment and diagnosis

_____ HIV/AIDS diagnosis/treatment/testing

_____

_____ Sexually transmitted disease

Mental illness or psychiatric diagnosis/treatment

DISCLOSE THE FOLLOWING HEALTH INFORMATION

All health records _____ Health information from _____ (date) to _____ (date)

DELIVERY METHOD

USPS Mail ____ Fax to: (217)877-2522 Email to_____ Will Pick Up_____

Mail to: _____

MY RIGHTS:

I understand I do not have to sign the authorization to obtain health care benefits (treatment, payment, or enrollment). I may revoke the authorization in writing. Please read our Privacy Notice to view the process for revoking this authorization. I understand that although the information will be encrypted and sent with a secure password, email is not a secure method of transmission. Once the information I have authorized to be disclosed reaches the noted recipient, that person or organization may choose to re-disclose it, at which time it may no longer be protected under this entities' privacy control.

Signature: Date:

(patient, guardian, or authorized representative)

This authorization will expire 90 days from the date signed. Possible copying fee required.

AUTHORIZATION TO SEND TEXT MESSAGES

Patient Name: _____

Date of Birth: _____

By signing this form, I authorize this office to send text messages to my cell phone to convey pertinent information regarding my appointment and other important information related to my care. I understand that standard text messaging rates may apply to any messages received from this office. I also understand that I or a representative of this office may revoke (cancel or opt out) this permission in writing at any time. I agree not to hold this office, its staff or the doctor liable for any electronic messaging charges or fees generated by this service. I further agree that in the event my cell phone number and or cell provider changes I will inform the office.

Name:_____

Cell Phone #: _____

Cell Phone Provider:(AT&T, T-Mobile, Sprint, etc.) _____

☐ **I decline and DO NOT want to receive text messages at this time.**

☐ **I accept and DO want to receive text messages.**

Initial _____ This permission form will remain in effect or until revoked by me or the office.

Patient Signature: _____

Date: _____

Privacy Disclaimer: This text message program is provided as a service to the patient to give important information in a timely manner. Your information will not be sold, distributed, or in any other way shared with entities or affiliates outside of this office.

Decatur Back and Neck Center
3350 N. Water Street, Suite A, Decatur, IL
217-877-2404

Insurance Information

Date _____ Patient Name _____ Date of Birth _____

Insurance Type Check all those that apply

Self-Insurance
- ☐ Personal Health Insurance (not sponsored by employer)
- ☐ Health Savings Account (HSA)
- ☐ Medicare Savings Account (MSA)
- ☐ Other _____

Employer Sponsored (Private Sectors)
- ☐ Group Health Insurance
- ☐ Self-Funded Benefit Plan
- ☐ Health Reimbursement

Government (Public Sectors)
- ☐ Medicare Part B
- ☐ Medicare Part C

Other
- ☐ Personal Injury (Auto, etc.)
- ☐ Workers' Compensation
- ☐ other _____

Insurance We need a copy of your card(s) for our records.

Insurance Company_____ Phone # ( ) _____

Insured's Name_____ ID/Policy # _____

Insurance Company_____ Phone # ( ) _____

Insured's Name_____ ID/Policy # _____

My Authorization

I authorize the **release** of any medical or other information necessary to process my claims. I also **request** payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

x_____ _____
Signature of patient or person acting on patient's behalf Date

---

My Financial Responsibility

I certify that the above information is correct. I understand that I am personally **financially responsible** for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, copayments, or non-covered services as may be required by my insurance plan.

x_____ _____
Signature of patient or person acting on patient's behalf Date