Wilkins Spinal Care DRS Severe Back Pain Solution Program
Patient Information

Date: ____________________

Name: ______________________________ Age: ____ Birthday: __________ Sex: M / F

Address: ____

City: ______________________________ State: _________ Zip: ______________

SS#: __________________________

Home Phone: ______________________ Cell Phone: ________________________

Best place to reach you: Home / Cell May we leave a message: Yes / No

Email address: ____

Employer: _______________________ Occupation: ___________________________

Length of employment: ____________

Marital status: Single / Married / Widowed / Divorced

Spouse's name: ____

Emergency contact: ____________________________________

Emergency phone: __________________________

What is your main problem or symptom: ______________________________________

Would you consider this problem:

MINIMAL (Annoying, but causing no limitations)

SLIGHT (Tolerable, but causing minor limitations)

MODERATE (Sometimes tolerable, but causes limitations)

SEVERE (Causing significant limitations)

EXTREME (Causing limitations > 80% of the time)

Have you had ANY of the following in the last 12 months, or do you have any currently?

General:

Chills ____
Convulsions ____
Dizziness ____
Fainting ____
Fatigue ____
Fever ____
Headache ____
Loss of Sleep ____
Allergy ____
(to what ______________)
Loss of Weight ____
Nervousness ____
Numbness in hands ____
Numbness in feet____

Cardiovascular:

High Blood Pressure ____
Low Blood Pressure ____
Pain over Heart ____
Poor Circulation ____
Rapid Heartbeat ____
Previous Heart Problem ____(Describe____________________)
Slow Heartbeat ____
Stroke ____
TIA ____
Swollen Ankles ____
Varicose Veins ____
Aortic Aneurysm ____
Bruise Easily ____

Diseases/Conditions:

Appendicitis ____
Anemia ____
Arthritis ____
Abdominal Surgery ____
Bleeding Disorder ____
Blood Clot(s) ____
Cancer ____
High Cholesterol ____
Colon Problems ____
Diabetes ____
Hernia ____
Kidney Disease ____
Liver Disease ____
Low Back Pain ____
Pneumonia ____

Ears/Eyes/Nose/Throat:

Asthma ____
Crossed Eyes ____
Double Vision ____
Blurred Vision ____
Difficulty Swallowing ____
Deafness ____
Hearing Loss ____
Ear Pain ____
Thyroid Problem ____
Nose Bleeds ____
Sinus Problems ____
Sore Throats ____

Gastro-Intestinal:

Gas ____
Colon Trouble ____
Constipation ____
Diarrhea ____
Gallbladder Trouble ____
Hemorrhoids ____
Liver Trouble ____
Nausea ____
Stomach Ache ____
Poor Appetite ____
Poor Digestion ____
Vomiting ____
Bloating ____

Genito-Urinary:

Blood in Urine ____
Frequent Urination ____
Inability to Control Urine ____
Kidney Infection ____
Painful Urination ____
Prostate Trouble ____

Muscle/Joint/Bone:

Backache ____
Foot Trouble ____
Pain between Shoulders ____
Painful Tailbone ____
Stiff Neck ____
Spinal Curvature ____
Swollen Joints ____

Neurological:

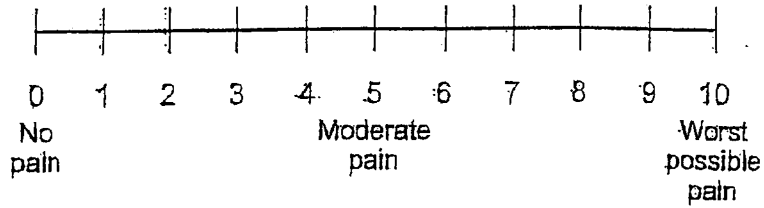
Seizures ____
Hand Trembling ____
Weakness ____
Difficulty w/ Speech ____
Loss of Memory ____
Loss of Coordination ____

Respiratory:

Chest Pain ________
Chronic Cough ________
Difficulty Breathing_______
Coughing/Spitting Blood_______

Patient Name: ______________________________ Date: ______________

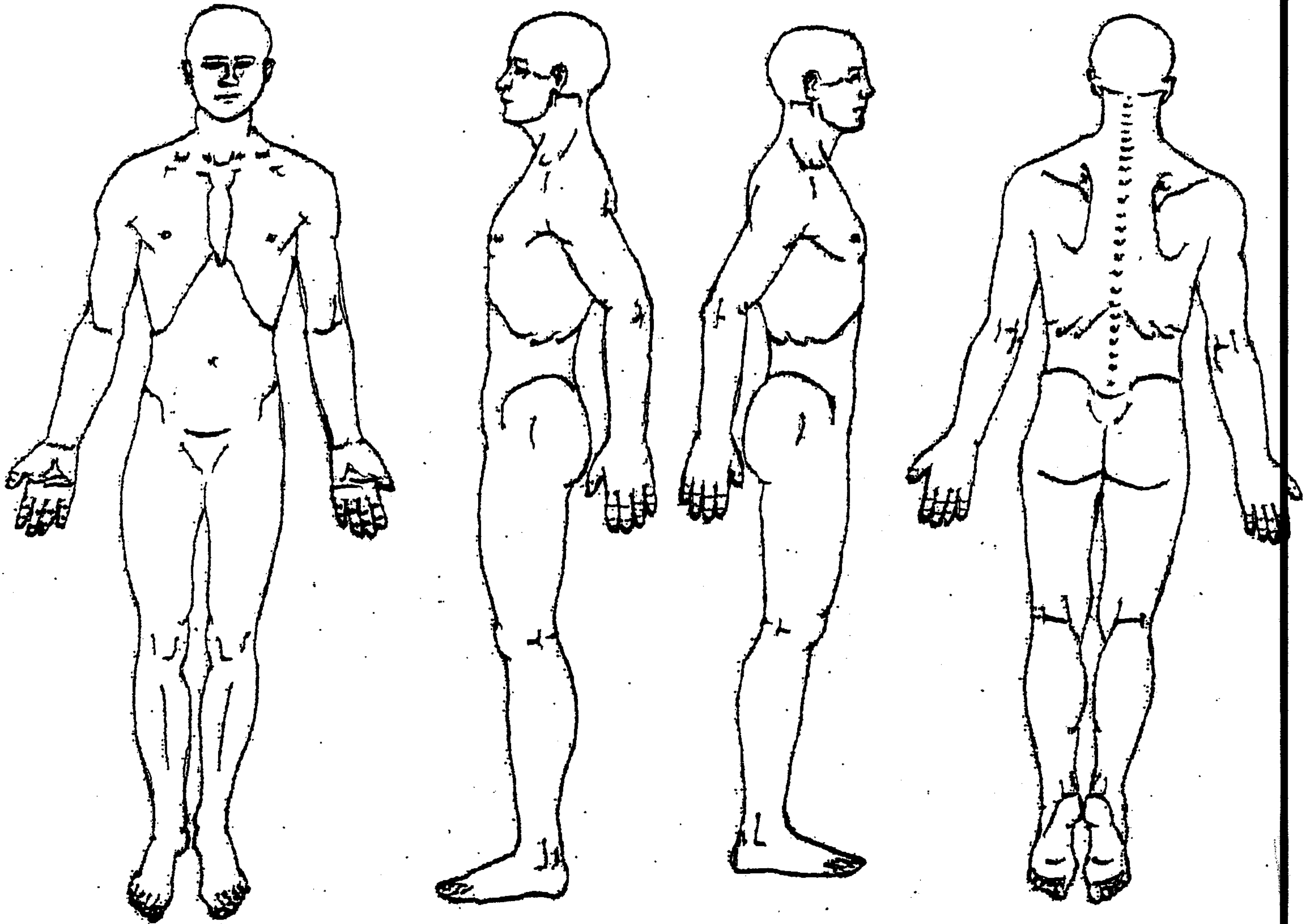
0-10 Numeric Pain Intensity Scale*



*If used as a graphic rating scale, a 10-cm baseline is recommended.
From: Acute Pain Management: Operative or Medical Procedures and Trauma, Clinical Practice Guideline No. 1. AHCPR Publication No. 92-0032; February 1992. Agency for Healthcare Research & Quality, Rockville, MD; pages 116-117.

PATIENT HISTORY

PAIN LOCATION



Please mark off the areas of your complaint on the diagram above.
Please use the following symbols on the pain diagram to accurately describe your condition.

PPP	Where you experience Pain
NNN	Where you experience Numbness
TTT	Where you experience Tingling
BBB	Where you experience Burning
CCC	Where you experience Cramping

Patient Signature:______________________________ Date:______________

Laurel Mountain Chiropractic Clinic

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.

USES AND DISCLOSURES: There are a number of situations where we may use or disclose to other persons or entities, your confidential medical information. Certain uses and disclosures will require you to sign an acknowledgement that you received our notice of privacy practices including treatment, payment and health care operations. Any use or disclosure of your protected health information, required by law or emergency circumstances may be made without your acknowledgement or authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

USE IN DISCLOSURE WITHOUT PATIENT ACKNOWLEDGEMENT OF THIS NOTICE: We will attempt in good faith to obtain your signed acknowledgement that you received this notice to use and disclose confidential medical information for the following purposes:

Treatment: We will use your medical information to make decisions about the provision, coordination, or management of your health care, including diagnosing your condition and determining appropriate treatment for that condition. It may also be necessary to share your medical information with another health care provider who we need to consult with respect to your care. We may also disclose certain information to a physical therapist to provide therapy under appropriate circumstances, or to a facility or other provider, should you require surgery or other hospital care. These are only examples of uses and disclosures of medical information for treatment purposes, and it may or may not be necessary in your case.

Payment: We may need to use or disclose information in your medical record to obtain reimbursement for you or your health insurance plan or another insurer for our services rendered to you. This may also include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for purposes of reimbursement. This information may also be used for billing, claims management, and collection purposes together with related health care data processing through our system

Operations: Your medical records may be used in our business planning and development operations including improvement in our methods of operation and general administrative functions. We may also use the information in our overall compliance planning, medical review activities and arranging for legal and auditing functions.

USE AND DISCLOSURE WITHOUT ACKNOWLEDGEMENT OR AUTHORIZATION: There are certain circumstances under which we may use or disclose your medical information without first obtaining your acknowledgement or authorization. The circumstances generally involve public health and oversight activities, law enforcement activities, judicial and administrative proceedings, and in the event of death. We are required to report information to certain agencies concerning certain communicable diseases, sexually transmitted diseases, and HIV/AIDS. We are also required to report instances of suspected or documented abuse, neglect, or domestic violence. We are required to report to appropriate agencies and law enforcement officials, information that you or another person are in immediate threat or danger to your health or safety as a result of violent activity. We must also provide medical information when ordered by a court of law to do so.

AUTHORIZATION FOR USE OR DISCLOSURE: Except as outlined in the above sections, your medical information will not be used or disclosed to any other person or entity without your authorization, which may be revoked at any time. Except to the extent , disclosure has been made to the government entities required by law to maintain confidentiality of the health treatment, drug and alcohol abuse, HIV/AIDS, or sexually transmitted diseases which may be contained in your medical records. We will not disclose medical record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident or to educational authorities without your written authorization.

ADDITIONAL USES AND DISCLOSURES: We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

INDIVIDUAL RIGHTS: You may have certain rights with respect to your medical record information, as follows:

1.) You may request that we restrict the uses and disclosure of your medical record information for treatment, payment, and operations or restrictions involving your care or your payment related to that care. We are not required to agree to the restrictions; however, if we agree we will comply with it, except with respect to emergencies, disclosure of information to you, or if we are required by law to make a full disclosure without restriction.

2.) You have the right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If this is required, you will be charged a fee and be required to specify the alternative address or method of contact and how payment will be handled.

3.) You have a right to inspect, copy, and request an amendment to the medical records. Access to your medical records will not include psychotherapy notes or information compiled in anticipation for use in a civil, criminal, or administrative action or proceeding or for which your access is otherwise restricted by law. We will charge you a reasonable fee for providing a copy of your medical records or a summary of those records at your request, which includes the cost of copying, postage, or preparation of an explanation or summary of the information.

4.) All requests for inspection, copying and/or amending information in your medical records must be made in writing and addressed to Rhonda Wells at the address noted below.

5.) You have a limited right to receive in accounting of all disclosures we make to other persons or entities of your medical records information except for disclosures required for treatment, payment, and health care operations, disclosures that require an authorization, disclosures incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting and any 12 month period; however, we will charge you a reasonable fee for each subsequent request for accounting within the same 12 month period.

6.) You have the right to obtain a paper copy of this notice.

7.) All requests related to your right, herein must be made in writing and addressed to Rhonda Wells at the address noted below.

OUR DUTIES: We have the following duties with respect to the maintenance, use and disclosure of your medical records: 1.) We are required by law to maintain the privacy of the protected health information in your medical records and to provide you with this notice of its legal duties and privacy practices with respect to that information. 2.) We are required to abide by the terms in this notice that are currently in effect.3.) We reserve the right to change the terms of this notice at any time, making the new provisions effective for all health information in medical records we have and continue to maintain. All changes in this notice will be prominently displayed and available at our office.

COMPLAINTS: You may file a written complaint to the Secretary of Health and Human Services if you believe your privacy rights, with respect to confidential information in your medical records have been violated. All complaints must be in writing and addressed to Rhonda Wells (in case of the complaint to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information about complaints is available online at the government website: http://www.nhs.gov/ocl/hippa

CONTACT PERSON: All questions concerning this notice or requests made pursuant to it, should be addressed to:

Maria Chappell or Brian Steinert, 372 East Main Street, Mt. Pleasant P.A 15666

EFFECTIVE DATE: This notice is effective December 5, 2018 and applies to all protected health Information contained in your medical records maintained by us. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to DHHS, Office of Civil Rights, 200 Independence Ave. S.W. room 59F HHH Building Washington D.C 20201.

This notice is effective as of December 5, 2018.

I have read the privacy notice and understand my rights contained in this notice.

By way of my signature, I provide Laurel Mountain Chiropractic Clinic, Larry E. Wilkins, D.C., P.C. with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment, and health care operations as described in the privacy notice.

_______________________________ _______________________ ____________

Patients Name (PRINT) Patients Signature Date

____

Authorized Facility Signature Date

Informed Consent

Informed Consent to Chiropractic Examination, Diagnostic Procedures, Chiropractic Adjustments and Care, and Axial Decompression Treatment

I hereby request and consent to the performance of: physical examinations and evaluations and performance of any tests or X-rays required to be performed to diagnose my condition(s), of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, of Axial Decompression on me (or on the patient named below, for whom I am legally responsible) by or under the supervision of the doctor of chiropractic named below and/or other licensed doctors of chiropractic: who now or in the future treat me while employed by, working, or associated with, or serving as a back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel, the nature and purpose of Axial Decompression, chiropractic adjustments and other procedures, I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest.

I have read, or had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

To be completed by patient:

To be completed by patient's representative if necessary, e.g., if patient is a minor or is physically or mentally incapacitated.

____
Print Patient's Name

____
Signature of Patient

____
Print Name of Patient's Representative

____
Date Signed

____
Signature of Patient's Representative

As: ______________________________ Date: ____________
Relationship of Authority of Patient Representative

<u>To be completed by doctor or staff:</u>

Wilkins Spinal Care
372 East Main Street
Mt. Pleasant, Pennsylvania 15666

Larry E. Wilkins, D.C.

Witness to Patient's Signature ______________________ Date: ____________

Review Informed Consent

- [ ] Met face to face with the patient
- [ ] Reviewed each component:
    - [ ] The patient's diagnosis/condition and the proposed treatment, modality, or procedures for correction
    - [ ] The relevant risks and benefits of the proposed treatment, modality, or procedures
    - [ ] Alternative treatment or procedures that are available to the patient and the relative risks, benefits, and uncertainties related to each alternative
    - [ ] The risk and/or benefits of not receiving or undergoing any treatment or procedure
    - [ ] The assessment of the patient's understanding of the information provided
    - [ ] The acceptance by the patient to undergo the recommended treatment, modality or procedure
- [ ] The information reviewed is contained within the informed consent form
- [ ] The patient was competent and understood the information
- [ ] The patient was voluntarily signed the associated informed consent form

______________________________ ______________________________

Doctor's Signature Date

Wilkins Spinal Care
372 East Main Street
Mt. Pleasant, Pennsylvania 15666

Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms off our notice may change. If we change our notices, you may obtain a revised copy by requesting one at the front desk

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

By my signature below, I acknowledge that I have had the opportunity to review the Wilkins Spinal Care/Laurel Mountain Chiropractic Clinic Notice of Privacy Practices.

Patient Name (please print) ______________________________

Parent/Guardian Signature ______________________________

Date ______________________________

Witness ______________________________

______________________________/______________________________
(name and relationship) has permission to receive information regarding my records.

______________________________/______________________________
(name and relationship) has permission to receive information regarding my records.

Wilkins Spinal Care
372 East Main Street, Mt. Pleasant, PA 15666

OUR FINANCIAL POLICY

Thank you for choosing *Wilkins Spinal Care* as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your services provided here is considered part of your treatment. The following is a statement of our Financial Policy which we request you read and sign prior to any treatment. All patients must complete our Information and Insurance forms prior to seeing the doctor.

WE ACCEPT CASH, CHECKS, or CREDIT CARDS

REGARDING INSURANCE:
Your insurance policy is a contract between you and your insurance company. We are not a party to this contract; therefore, our policy is to have the patient, themselves, submit to their insurance carrier. We provide you with the proper documentation to submit your claims. As a courtesy to you, we will initially contact your insurance company and request your chiropractic benefits, when provided with your insurance cards. However, this is not a guarantee of payment for all or any of your fees.

Any balance remaining on your account, not subject to a financial repayment plan, after sixty (60) days will be subject to a $30.00 administrative fee for collection efforts as well as the current maximum interest rate allowed by law.

MEDICARE PATIENTS:
We do accept Medicare patients. Medicare coverage guidelines allow coverage for chiropractic manual manipulation of the spine only. These manipulations are limited to payment by Medicare, as to the "reasonable expectation that of recovery or improvement of function." Please be aware that Medicare may not consider charges "medically necessary" and deny claims, which is not the responsibility of *Wilkins Spinal Care*.

Thank you for reviewing our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy.

_____**Please check if you are a Medicare Patient and present your card.**
I have read the Financial Policy.

X ______________________________________ Date: ____________________
Signature of Patient or Responsible Party

Patient Name: ______________________________ HICN: ____________________

Date: ______________________________

Patient Name: ____

List any doctors who have been aware of your back or neck problems, may have prescribed medications, physical therapy, etc. or may have referred you to another doctor.

Doctor: ____

Address: ____

Telephone Number: ____

Doctor: ____

Address: ____

Telephone Number: ____

Doctor: ____

Address: ____

Telephone Number: ____

Doctor: ____

Address: ____

Telephone Number: ____

Doctor: ____

Address: ____

Telephone Number: ____

May we have your permission to send a letter to the above doctors informing them of your Axial Decompression? ________ Yes ________ No

Did any doctor refer you to Wilkins Spinal Care? ________ Yes ________ No

If Yes, Doctor's Name: ____

Authorized Representative Designation

I hereby designate, authorize, and convey to Wilkins Spinal Care ("Provider") to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan, including but not limited to with respect to internal appeals or litigation; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"), as provided in 29 *C.F.R.* §2560.5031(b)(4)), with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines or injunctive relief. By signing this form, I understand that Provider is not assuming any obligation or duty to assert such rights and I agree to release any claim I might have relating to Provider's exercise of such rights or the decision not to exercise such rights.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

______________________________ ______________
Patient Date

______________________________ ______________
Policyholder/Insured Date