HHCC Application For Treatment

Legal First Name: _____ MI: _____ Last Name: _____ Date: _____

I preferred to be addressed as: _____ DOB: _____ Age: _____ Gender: M F

Street: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Cell carrier: _____ Email: _____

Please circle your contact preference: *Home *Work *Cell *Email *Postal Mail

Marital Status: *Single *Married *Widow *Divorced *Domestic Partner

Occupation: _____ Employer: _____

Employer Address: _____

Spouse/Partner Name: _____ Ages of Children: _____

Spouse's Employer: _____ Spouse's Work Phone: _____

Language: *English *Spanish *Japanese *Chinese *Korean *French *German *Russian
*Other: _____

Race: *White *American Indian or Alaska Native *Asian *Native Hawaiian/Other Pacific Islander
*Black or African American *Decline to Answer *Other_____

Ethnicity: *Hispanic or Latino *Not Hispanic or Latino *Decline to Answer

Emergency Contact: _____ Phone Number: _____

Current Medical Physician: _____ Phone: _____

Whom may we thank for referring you to our office? _____

Insurance Information

We will make a copy of your insurance card/s. However, please complete the following information.

*Are you the policy holder? Y N If no, who is policy holder: Spouse Partner Parent Employer Other

Policy Holder's Name:
First Name: _____ M.I. _____ Last Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's Employer: _____

*Do you have secondary insurance coverage? Y N if yes, please complete the following:

Policy Holder's Name:
First Name: _____ M.I. _____ Last Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's Employer: _____

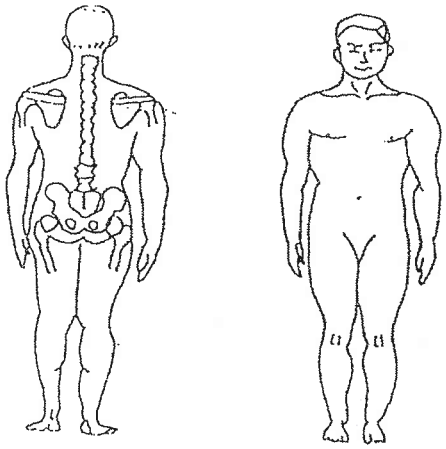
Medical Information

Please print your full legal name: _____

Date: _____

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain as well as any activity which brings on or aggravates the pain. For example: dull, sharp; constant, off and on; standing or sitting.

Complete these diagrams



Major Complaints

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PAIN SCALE- Circle and label one for <u>each</u> complaint listed above:

What is your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

No pain **Unbearable Pain**

What is your TYPICAL or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

No pain **Unbearable Pain**

What is your pain AT ITS WORST?

0 1 2 3 4 5 6 7 8 9 10

No pain **Unbearable Pain**

How often do you have pain during waking hours (Frequency)?

0 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How did this condition develop? What caused it? How did it start?

_____

_____

OVER ↓

Name: _____ **Date:**_____

When did it start?

_____

Any accidents, falls, or injuries that might have caused or contributed to your problem?

_____

Has this problem been getting better, worse, or staying the same?

_____

Is there anything you do that makes your condition better?

_____

What activity is your condition affecting? (Work, social, sports, household chores, sitting, sleeping…)

_____

Have you ever had this problem or similar problem before? If yes, please explain.

_____

Have you consulted a chiropractor or other physician about this problem in the past? If yes, please give name, dates and problem at the time.

_____

What is/are your goal(s) from receiving treatment? Pain relief? _____ Corrective care? _____
Other:_____

Is there any medical diagnosis for your present complaint?

_____

Have you ever been in an automobile accident? __ Past year ___ Past 5 years __Over 5 years ___ Never

Please list any surgeries you have had.

_____

Please list any medications you are currently taking and for how long.

_____

Please check if you currently have any of the following or have had them in the past:

- ❑ Heart attack
- ❑ High blood pressure
- ❑ Epilepsy/Seizures
- ❑ Arterial disease
- ❑ Blood Clots
- ❑ Swollen Joints
- ❑ Skin Conditions
- ❑ Cancer
- ❑ Drug/Alcohol Abuse
- ❑ Heart disease
- ❑ Stroke
- ❑ Kidney disease
- ❑ Liver Disease
- ❑ Varicose Veins
- ❑ Arthritis
- ❑ Influenza/Fevers
- ❑ Tuberculosis
- ❑ Smoking
- ❑ Heart operations
- ❑ Diabetes
- ❑ Lung disease
- ❑ Hepatitis C
- ❑ Difficulty Urinating
- ❑ Asthma/Allergies
- ❑ Unexplained Weight Loss
- ❑ HIV/Aids
- ❑ Pregnancy

Patient Signature (If minor, Parent or Guardian Signature):_____

Neck Index

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

Neck Index Score ☐

Back Index

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 ☐

X BACK

HELPING HANDS CHIROPRACTIC CENTER LC

INFORMED CONSENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment and any alternatives to the treatment. There are some risks that may be associated with chiropractic manipulation and massage treatment in particular you should note:

a. While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment.

b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment though no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.

c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spinal manipulation is extremely remote.

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years which have demonstrated it to be highly effective treatment for spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well being. ***The risk of injuries or complications from treatment is substantially lower than associated with many medical or other treatments, medications and procedures given for the same symptoms.***

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with Helping Hands Chiropractic Center.

Dated this _____ day of _____ 20_____

_____ _____

Printed Patient Name Patient Signature (or legal guardian)

Michael A. Faas, DC
Lane B. Myhree DC
Laura W. McChesney, DC

_____

Doctor Signature

HELPING HANDS CHIROPRACTIC CENTER

Financial Policy and Patient Agreement

We are glad to process all insurance paperwork for you. Please provide the receptionist with all your insurance information. We make every effort to advise our patients in advance if a service in the office is not covered by a particular insurance plan. Additionally, if you are a new patient, we do attempt to verify your coverage within 48 hours with your insurance company. We will then inform you of your insurance company's communication to us regarding your coverage, amount of unmet deductible, percentages, co pays, and/or other matters.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be advised that some and perhaps all the services provided may be "non-covered" services and/or considered not medically necessary under some medical insurance policies. You are personally responsible for payment of the fee regardless of whether the insurance company pays or not.

We are happy to set up a time to discuss your balance or a possible payment schedule. We accept cash, checks, American Express, Discover, Master Card or VISA. We also offer ChiroHealthUSA as a low cost alternative for uninsured, underinsured or non-covered services.

Interest shall accrue on all unpaid patient balances at the maximum rate allowed by law, currently eighteen percent (18%) annually.

INSURANCE BILLING PROCEDURES

If you have two or more insurances policies, we will bill your primary insurance only. We do not bill secondary or tertiary insurances.*

Upon request we will gladly provide you with a statement containing the necessary information for you to forward to your secondary insurance. You will need to wait until you get the primary insurance company's Explanation of Benefits (EOB) back before sending it in with your secondary's claim form as information on the EOB is needed for any secondary reimbursement.

*exception:
- Medicare claims with Medigap. For the most part, Medicare automatically forwards the Medicare EOB to your secondary insurance. Not all Medicare policies have Medigap.

CANCELLATION OF APPOINTMENTS

Please give us **24 hour advance notice** to cancel or change an appointment. You may be billed for a missed appointment or last minute cancellation if a pattern is evident.

If you have any questions about any of our policies, please feel free to talk with any of our staff including Dr. Michael A. Faas, Dr. Lane B. Myhree, and Dr. Laura W. McChesney.

I have read the Financial Policy and Patient Agreement above and Agree to my personal obligation and that if this is placed in the hands of an Attorney for enforcement or collection, the prevailing party shall be entitled to all costs incurred including Attorney fees and court costs, whether suit is filed or not.

Patient Name Printed:_____ **Date:** _____

Patient Signature: _____

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. ☐

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

HELPING HANDS CHIROPRACTIC CENTER LC
ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By **circling** the appropriate response below I authorize being contacted for practice reminders by:

Mail: Y N
Email: Y N at email address _____;
Telephone: Y N at number_____;
By voice mail: Y N

By **circling** the appropriate response below I authorize being contacted for greetings or promotions about the practice by:

Mail: Y N
Email: Y N at email address _____;
Telephone: Y N at number_____;
By voice mail: Y N

By **initialing** the line below I authorize the doctor to personally discuss with me products that may benefit my health or condition. _____

_____ _____
Patient Name (please print) Date

_____
Name of Parent, Guardian or Patient's legal representative

_____
Signature of Patient, Parent, Guardian or Patient's legal representative

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____

Michael A. Faas, D.C., D.A.B.C.O, A.C.C.O.
Diplomate, American Board of Chiropractic Orthopedists
Member, American College of Chiropractic Orthopedists

Lane B. Myhree, D.C.
Associate Clinic Director
Member of the Florida Chiropractic Association

Laura W. McChesney, D.C.
Member of the Florida Chiropractic Association

Personalized Programs for Pain and Injury Rehabilitation
Chiropractic • Exercise Therapy • Massage Therapy

CONSENT TO TREAT A MINOR

I authorize the doctors and staff of Helping Hands Chiropractic Center LC, to treat my minor child as they deem appropriate.

Please check the following as it applies:
[ ] I wish to be present at all of my child's treatment sessions.
[ ] I do not need to be present for my child's treatment sessions.

_____ _____
Child's name Child's birth date

_____ _____
Signature of parent or legal guardian Print name of parent or legal guardian

(_____) _____ _____
Contact phone number Date