Dr. Jennifer M. Wells, D.C.
*and Associates*

# PATIENT UPDATE FORM

## PERSONAL INFORMATION

**First Name:**__________________ **MI:**____ **Last Name:**_________________________ **Preferred Name:**_____________________

**Address:**__________________________________________ **City:**________________________ **State:**_________ **Zip:**__________

**Birthdate:**____/____/_____ **Age:**________ **Gender:** ☐ Male ☐ Female ☐ Unspecified **SSN:**_________-______-_________

**Primary Phone:**______________________ **Cell Phone:**__________________________ **Work Phone:**_______________________

**Email:**__________________________________________________________

*By providing my email address, I authorize my doctor to contact me via the email address provided.*

**Preferred Contact Method:** (check one) ☐ Primary Phone ☐ Cell Phone ☐ Work Phone ☐ Email

**Occupation:**________________________________ **Employer:**______________________________________________________

**Status:** (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated **Children?:** ☐ Yes ☐ No How Many:______

**Spouse's Name:** (if applicable)_________________________________________

**Emergency Contact:** (Name, Relationship, Phone #)______________________________________________________________

**How were you referred to Back Country Chiropractic?:**__________________________________________________________

## INSURANCE OR PRIVATE PAY INFORMATION

**Type of Insurance:** ☐ Private Insurance ☐ Medicare ☐ Auto Insurance ☐ Worker's Comp ☐ Other____________________

**Primary Insurance Carrier:**_________________________________________________________ **Phone:**_____________________

**Policy #:**___________________________ **Group #:**__________________________ **Claim #:**____________________________

**Name of Policy Holder:**____________________________________ **Relationship to Patient:**___________________________

**Policy Holder's Birthdate:**____/____/_____ **Policy Holder's SSN:**_________-______-_________ **Employer:**__________________

**Is patient covered by another insurance?** ☐ Yes ☐ No

**Secondary Insurance Carrier:**_______________________________________________________ **Phone:**_____________________

**Policy #:**___________________________ **Group #:**__________________________ **Claim #:**____________________________

**Name of Policy Holder:**____________________________________ **Relationship to Patient:**___________________________

**Policy Holder's Birthdate:**____/____/_____ **Policy Holder's SSN:**_________-______-_________ **Employer:**__________________

**ASSIGNMENT/AUTHORIZATION/RELEASE/ACKNOWLEGEMENT:** (check all applicable boxes and initial)

☐ I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Back Country Chiropractic all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that "co pays" are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services. **Initial:**_________

☐ Some Insurance plans are not allowing any treatment other than a basic adjustment or manipulation 98940 paid code that is medically necessary only. Therefore, any "extraspinal" adjustments or treatments by the doctor, to include massage by the doctor 97124, flexion-distraction 97012, or electrical stimulation 97014 *MAY* be an additional $10 to $25 fee on top of your regular co-pay or insurance. Also, any care deemed not medically necessary by your insurance will be reduced to our out-of-pocket daily fee schedule. **Initial:**_________

☐ **Private Pay/Cash:** By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered. Person responsible for this account:__________________ **Initial:**_________

☐ **Cancellation or No-Show Fees:** Cancellations for adjustments or massages without a 24-hour notice may be subject to a $25 fee for adjustments, $30 for 1-hour massages, and $15 for half-hour massages. **Initial:**_________

☐ **A Credit Card on File Requirement:** By checking this box, I authorize my credit card on file to be charged if not paid for at the time of service for the following: deductibles, co-insurance, non-covered therapies as stated above, cancellations without a 24-hour notice, and no-show fees or any care deemed not medically necessary by my insurance company. **Initial:**_________

**CC #:**_________ _________ _________ _________ **Exp. Date:**_____/_____ **CVV:**_________ **Signature:**____________________

**Signature of Patient, Parent, or Legal Guardian: X**_______________________________________________ **Date:**_______________

## REASON FOR VISIT

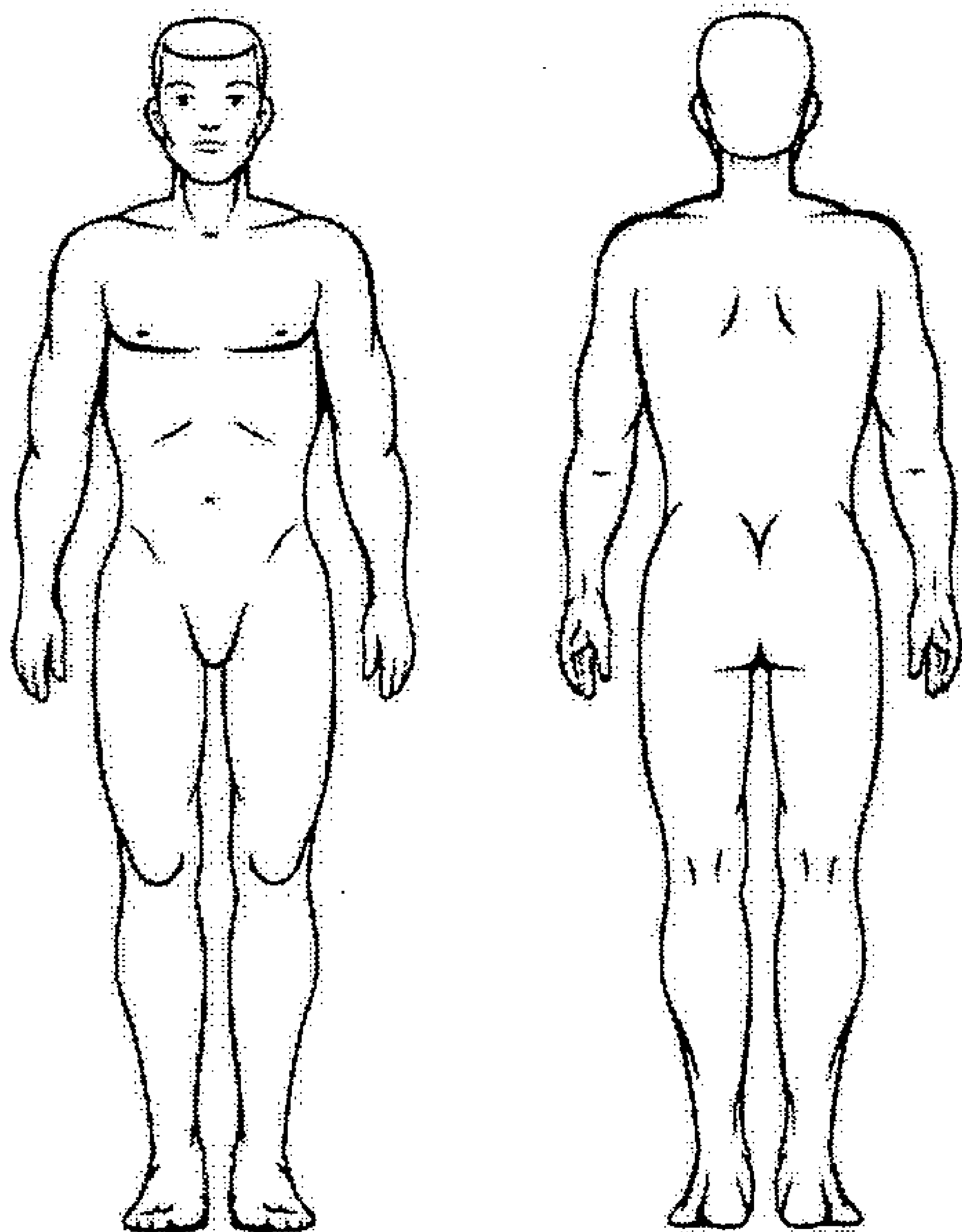
**What is the reason for your visit today?** ☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain ☐ Other__________

**What caused this complaint(s)?**____________________

**When did this complaint begin?**___/___/___ **Is it getting worse?** ☐ Yes ☐ No ☐ Constant ☐ Comes and Goes

**Have you had this or similar complaint in the past?** ☐ Yes ☐ No If "Yes", when?__________

**What does your complaint(s) feel like? Circle all that apply:** *Sharp / Dull / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Numbness / Other:*__________



← **Please Circle or make an "X" on the body diagram to the left where you have pain or other symptoms.**

*Area for doctor's notes:*

**On the scale below, please circle the severity of your main complaint right now:**

| ***No Pain*** | | | | ***Moderate Pain*** | | | | | ***Worst Possible Pain*** |
|---|---|---|---|---|---|---|---|---|---|
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |

**What area(s) does the pain radiate, shoot, or travel to?** (if applicable)__________

**What aggravates this complaint(s)? Circle all that apply:** *Sitting / Standing / Walking / Getting Up From Seat / Walking Stairs / Inactivity / Sleeping / Physical Activity / Exercise / Movement / Bending Forward / Bending Backward / Twisting / Reaching / Lifting / Desk Work / Coughing / Everything / Unknown / Other:*__________

**What relieves this complaint(s)? Circle all that apply:** *Sitting / Standing / Walking / Resting / Exercise / Movement / Stretching / Massage / Chiropractic / Heat / Ice / Lying Down / Medication / Acupuncture / Nothing / Other:*__________

**Are you interested in learning more about acupuncture:** ☐ Yes ☐ No

**How often do you experience your symptoms?** ☐ 25% of the day ☐ 50% of the day ☐ 75% of the day ☐ 100% of the day

**Time of complaint: Check appropriate box:** ☐ Morning ☐ As day progresses ☐ Afternoon ☐ Evening ☐ While sleeping ☐ During activities ☐ After activities ☐ Symptoms are constant and do not change ☐ Other:__________

**With time, are your symptoms:** ☐ Improving ☐ Worsening ☐ Not changing

**Have you seen other doctors for this complaint?** ☐ Yes ☐ No If "Yes", please provide the following information:
Doctor's Name:__________ Date Consulted:___/___/___ Diagnosis:__________

**Is this condition interfering with your: Circle all that apply:** *Sleep / Getting in or out of bed or chair / Personal care / Travel / Work / Recreation / Lifting / Walking / Standing / Daily routine / Social activities / Exercise / Other:*__________

**Is your complaint interfering with your daily activities?** ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

**NAME:**____________________ **DATE:**__________

# Patient Summary Form

PSF-750 (Rev: 7/1/2015)

**Instructions**
Please complete this form within the specified timeframe. All PSF submissions should be completed online at www.myoptumhealthphysicalhealth.com unless otherwise instructed.

Please review the Plan Summary for more information.

## Patient Information

Patient name Last | First | MI

○ Female
○ Male

Patient date of birth

Patient address | City | State | Zip code

Patient insurance ID# | Health plan | Group number

Referring physician (if applicable) | Date referral issued (if applicable) | Referral number (if applicable)

## Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form) | 2. Federal tax ID(TIN) of entity in box #1

3. Name and credentials of the individual performing the service(s) — 1 MD/DO 2 DC 3 PT 4 OT 5 Both PT and OT 6 Home Care 7 ATC 8 MT 9 Other ____

4. Alternate name (if any) of entity in box #1 | 5. NPI of entity in box #1 | 6. Phone number

7. Address of the billing provider or facility indicated in box #1 | 8. City | 9. State | 10. Zip code

## Provider Completes This Section:

**Date you want *THIS* submission to begin:**

**Cause of Current Episode**
(1) Traumatic (2) Unspecified (3) Repetitive (4) Post-surgical → (5) Work related (6) Motor vehicle

**Date of Surgery**

**Type of Surgery**
(1) ACL Reconstruction
(2) Rotator Cuff/Labral Repair
(3) Tendon Repair
(4) Spinal Fusion
(5) Joint Replacement
(6) Other ____

**Diagnosis (ICD codes)**
*Please ensure all digits are entered accurately*
1°
2°
3°
4°

**Patient Type**
(1) New to your office
(2) Est'd, new injury
(3) Est'd, new episode
(4) Est'd, continuing care

**Nature of Condition**
(1) Initial onset (within last 3 months)
(2) Recurrent (multiple episodes of < 3 months)
(3) Chronic (continuous duration > 3 months)

**DC ONLY**
**Anticipated CMT Level**
○ 98940 ○ 98942
○ 98941 ○ 98943

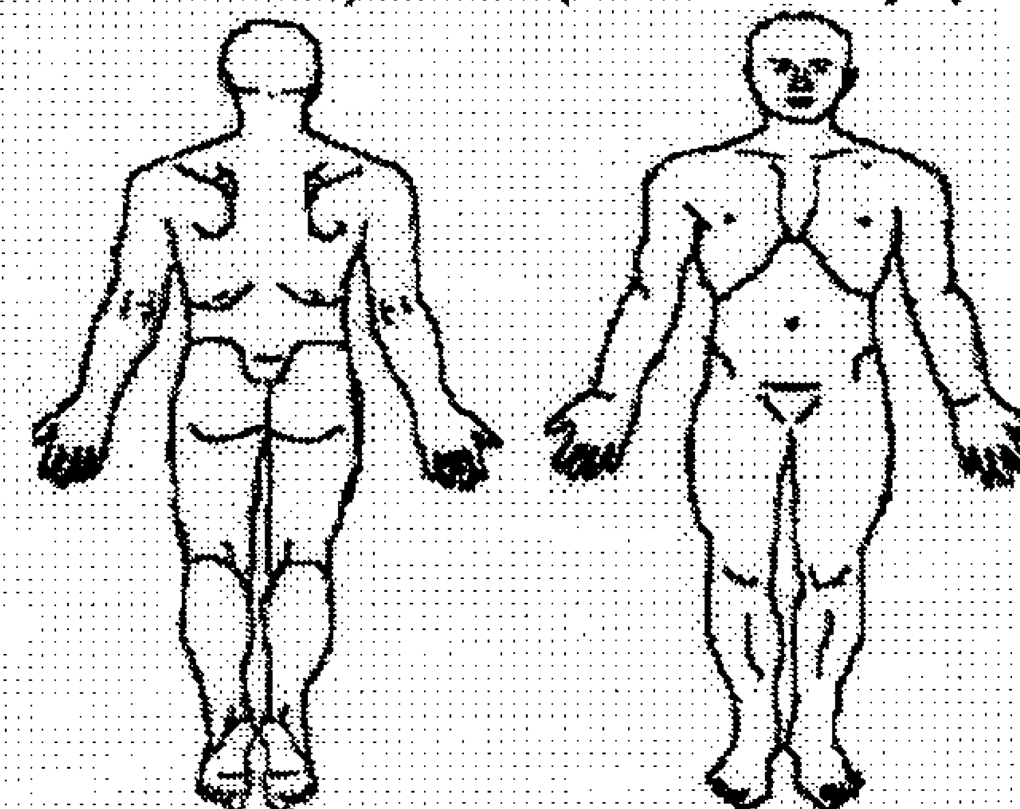
**Current Functional Measure Score**
Neck Index | DASH | ____ (other FOM)
Back Index | LEFS

## Patient Completes This Section:

(Please fill in selections completely)

**Symptoms began on:**

Indicate where you have pain or other symptoms:



**1. Briefly describe your symptoms:**

**2. How did your symptoms start?**

**3. Average pain intensity:**
Last 24 hours: **no pain** (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) **worst pain**
Past week: **no pain** (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) **worst pain**

**4. How often do you experience your symptoms?**
(1) Constantly (76%-100% of the time) (2) Frequently (51%-75% of the time) (3) Occasionally (26% - 50% of the time) (4) Intermittently (0%-25% of the time)

**5. How much have your symptoms interfered with your usual daily activities?** (including both work outside the home and housework)
(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

**6. How is your condition changing, since care began at *this* facility?**
(0) **N/A — This is the initial visit** (1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better

**7. In general, would you say your overall health right now is...**
(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor

**Patient Signature:** X ____ **Date:** ____

# Neck Index

Form N1-100

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.

### *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.

### *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).

### *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.

### *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.

### *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.

### *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.

### *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.

### *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.

### *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

Form BI100

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*

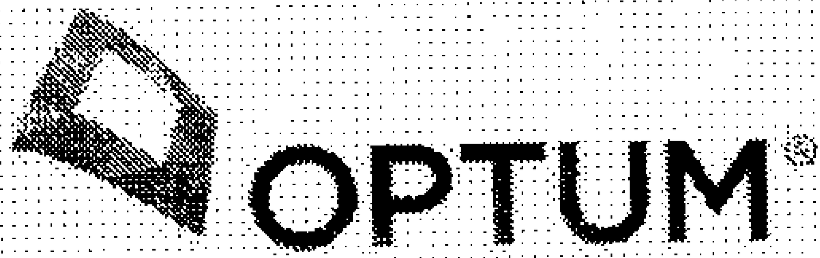
⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.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




# Patient Billing Acknowledgement Form
# Non-Covered Services**

Under your health plan, you are financially responsible for co-payments, co-insurance and deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non-covered services as defined by your health plan contract. For example, this may include items such as supplies, vitamins, or durable medical equipment.

The services or products listed below are not covered according to your health plan. Your acknowledgement below indicates that you have been advised of this information and that you agree to pay for the listed services or products.

**** Not for use in New Jersey**

**PROVIDER**

*Services to be provided:*

☐ Supply • supplements 10-80.00

☐ DME • cervical decompression collar 30.00
• deluxe cervical pillow 50.00
• lumbar brace 45-55.00
• ice pack 10-30.00

☐ Modalities/Procedures ______ ☐ Other ______
• massage by doctor or therapist 10.00 → 75.00
• laser treatment 25.00 30.00

Time frame from 6/1/19 through ______

Schedule/details (The doctor performs a 1-unit massage w/ every treatment @ 10.00 xtra + usual co-pay)

Provider Signature: [signature]

**PATIENT**

I ______________________, acknowledge that I have been told
Patient Name – Printed or Typed
in advance by my provider that the services/products listed above are not covered by my Health Plan. I agree to pay for these non-covered services.

Patient/Guardian Signature ______________________ Date ______________________

# Patient Billing Acknowledgement Form
# Maintenance/Elective Care**

Under your health plan, you are financially responsible for co-payments, co-insurance or deductibles for covered services. You are also financially responsible for all non-covered services, including care determined to be elective or maintenance.

Maintenance/Elective care is treatment that does not significantly improve a clinical condition. While being treated for a chronic condition, you may elect to receive care beyond that which is determined to be medically necessary. You may also choose to receive maintenance care once maximum benefit from treatment has been reached.

If, during the course of Maintenance/Elective Care, you develop a new condition or a previous condition becomes significantly worse, care may no longer be considered Maintenance/Elective and may then be covered by your health plan. Your provider must submit a request for insurance coverage.

** **Not for use in New Jersey**

**PROVIDER**

*Services to be provided are listed below:*

☒ Chiropractic Manipulative Therapy 50.00 • supportive or maintenance care ☐ In-~~Home Care~~ ____

☐ Modalities/Procedures laser tx 25-30.00 • massage by doctor 10.00 ☐ Other massage by therapist 35.00 → 75.00

Time frame from 6/1/19 through ____________

Schedule/details The doctor performs a 1-unit massage on every visit → 10.00 (included in maintenance care)

Provider Signature: [signature]

**PATIENT**

I ______________________, acknowledge that I have been told
Patient Name – Printed or Typed
in advance by my provider that the services/products listed above are not covered by my Health Plan. I agree to pay for these non-covered services.

Patient/Guardian Signature ______________________ Date ______________

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