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 fee as follows: $30 for adjustments, $40 for half-hour massages, and $80 for 1-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

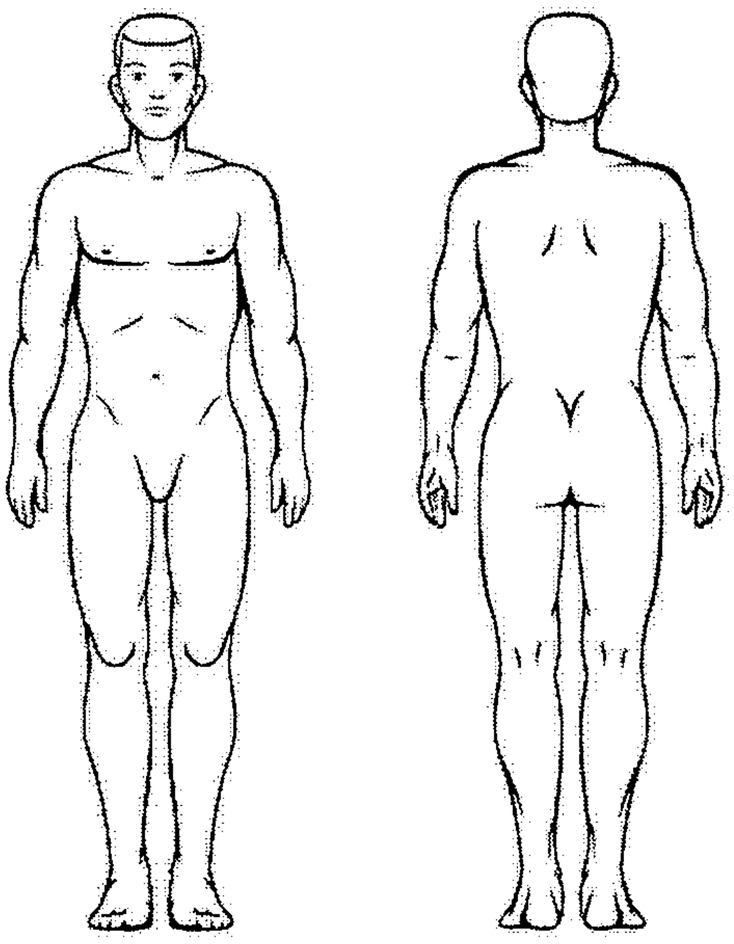
**What is the reason for your visit today?** ☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain ☐ Other_____

**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:**_____

## HEALTH HISTORY

| Please check **ALL** of the health conditions below that apply to **you** currently or in the past. | | | | **Family History** Mark **ALL** conditions that run in your family | | Relationship: (Father,Mother,Sister,Brother) |
|---|---|---|---|---|---|---|
| ☐ | Osteoarthritis/Degenerative Joint Disease | ☐ | **Whiplash Injury** *Date of injury:* | ☐ | Cancer *Type:* | |
| ☐ | Asthma | ☐ | Headaches | ☐ | Anemia | |
| ☐ | Diabetes ☐ Type I ☐ Type II Was your blood/lab work test for hemoglobin A1c > 9.0%? ☐ Yes ☐ No ☐ Not Sure | ☐ | Joint Pain (circle location of pain): Shoulder, Elbow, Hip, Knee, Ankle Other:_____ | ☐ | Diabetes (check one) ☐Type I ☐ Type II | |
| ☐ | Anemia | ☐ | Migraines | ☐ | Heart Problems / Stroke | |
| ☐ | Cancer/Tumor | ☐ | Osteoporosis /Osteopenia | ☐ | High Blood Pressure | |
| ☐ | Rheumatoid Arthritis | ☐ | Epilepsy / Seizures | ☐ | Genetic Disorders | |
| ☐ | Depression/ Anxiety | ☐ | Fibromyalgia / Chronic Fatigue | ☐ | Rheumatoid Arthritis | |
| ☐ | Disc Herniation | ☐ | Genetic Disorders | ☐ | Other (List): | |
| ☐ | High Blood Pressure /Hypertension | ☐ | Please list any other medical conditions: | | | |
| ☐ | Heart Disease / Stroke | | | | | |

**WOMEN ONLY:** **Currently Pregnant?** ☐ Yes ☐No **Painful /Abnormal Menstrual Cycle?** ☐ Yes ☐ No **Menopause?** ☐ Yes ☐ No **Miscarriage?** ☐ Yes ☐ No **Do you have children?** ☐ Yes ☐ No **If "Yes"**, type of birth? **Circle** Vaginal or C-Section

**FRACTURES (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date:)**

_____

_____

**SURGERIES and/or HOSPITALIZATIONS (List and Date):**

_____

_____

**Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days?** ☐ Yes ☐ No

**List current prescription medications**, including frequency and dosage if known. **If there are NO current medications, check here** ☐

| *Name of prescription medication* | *Dosage/Start date* | 4. | |
|---|---|---|---|
| 1. | | 5. | |
| 2. | | 6. | |
| 3. | | 7. | |

**List any known allergies you have had to prescription medications. If NO medication allergies are known, check here** ☐

1._____ 2._____

## SOCIAL HISTORY

**Do you exercise?** ☐ Yes ☐ No **Times per week?** **Intensity?** ☐ Light ☐ Moderate ☐ Strenuous **Type?**

**Do you currently smoke tobacco of any kind?** ☐ Yes ☐ Former smoker ☐ Never been a smoker

**If "Yes"**, how often do you smoke: ☐ Current every day smoker ☐ Current sometimes smoker **Circle level below ↓:**

**If "Yes"**, what is your level of interest in quitting smoking? ( 0 = NO interest, 10=very interested) **0 1 2 3 4 5 6 7 8 9 10**

**Do you drink alcohol?** ☐ Yes ☐ No **How many drinks per week?** **For how many years?**

**Do you drink caffeine?** ☐ Yes ☐ No **How many drinks per day?** **What type?** ☐ Coffee ☐ Tea ☐ Soft Drinks ☐ Energy Drinks

**Do you take pain killers?** ☐ Yes ☐ No **How often?** ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely

**What type?** ☐ Aspirin ☐ Ibuprofen ☐ Tylenol ☐ Other_____

**What do your work duties include?** ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor ☐ Other:

**Please describe your overall health right now?** ☐ Excellent ☐ Very Good ☐ Good ☐Fair ☐ Poor

**What is your current stress level?** ☐ Mild ☐ Moderate ☐ High

**Have you seen a chiropractor in the past?** ☐ Yes ☐ No **If so, when was your last treatment?**

**What are your hobbies?**

**NAME:**_____ **DATE:**_____

# INFORMED CONSENT

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

***The nature of the chiropractic adjustment:***

The primary treatment I use, as a Doctor of Chiropractic, is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

***Analysis / Examination / Treatment***

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

- Spinal Manipulative Therapy
- Palpatation
- Vital Signs
- Range of Motion Testing
- Orthopedic Testing
- Basic Neurological Testing
- Laser Treatment
- Postural Analysis
- EMS
- Ultrasound
- Hot/Cold Therapy
- Radiographic Studies
- Other (please explain)_____

***The material risks inherent in chiropractic adjustment.***

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation 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 treatments. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

***The probability of those risks occurring.***

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

***The availability and nature of other treatment options.***

Other treatment options for your condition may include:

1. Self-administered, over-the-counter analgesics and rest
2. Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
3. Hospitalization
4. Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

***The risks and dangers attendant to remaining untreated.***

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

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE <u>CHECK THE APPROPRIATE BOX AND SIGN BELOW</u>:**

☐ **I have read** or ☐ **have had read to me** the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the Doctor of Chiropractic at Back Country Chiropractic and have had my questions answered to my satisfaction. I certify that the information I have provided is correct to the best of my knowledge. I will not hold my doctor or any staff member at Back Country Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

**Patient's Name:**_____ **Signature: X**_____ **Date:**_____

**Physician's Name:**_____ **Signature: X**_____ **Date:**_____

# HIPAA 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.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

**Use and Disclosures of Protected Health Information:**
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**May we phone, email or send you a text to confirm appointments?** ☐ Yes ☐ No

**May we leave a message on phone numbers or with any family members?** ☐ Yes ☐ No

**May we discuss medical condition with any member of your family?** ☐ Yes ☐ No

**If so, list name(s) of member(s) allowed?**_____

_____

**Patient Name (print):**_____

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

# Member Self-Pay Billing Agreement:

## Chiropractic

**Important Notice:** You may have additional coverage options for these services through your medical insurance benefits. We recommend that you contact your health plan to inquire regarding coverage for these services prior to signing this form. Your knowledge of your insurance benefits is your responsibility. We attempt to verify insurance as a courtesy, however, sometimes information verified is not correct or clear regarding some covered benefits and eligibility is NOT a guarantee of payment.

Also, "Supportive Care" or "Maintenance Care" is NOT a covered benefit under most health insurance plans, therefore, any visits not deemed medically necessary by your insurance company after the fact will be your responsibility. We will do our very best to be your advocate and get your visits paid by your insurance for the services provided. However, in case we are unable to recover payment for those services, we have you sign this acknowledgement form as notification of charges that may not be covered or are not covered by your plan in advance. We appreciate your patronage to our office and for your understanding that every health plan is different and complicated patient by patient.

I, _____, a member being treat by Dr. Jennifer Wells and/or
(Name of Patient/Member/Subscriber)
Associates do hereby acknowledge that a certain portion of my care will not or may not be covered by my insurance company or health plan under the terms of my Benefit Plan with _____.
(Name of Health Plan)

I understand and agree to be responsible to self-pay for the following services:

**LIST OF SERVICES TO BE PAID FOR BY MEMBER/PATIENT:**

| Date: | Procedure: | Charge: |
|---|---|---|
| _____ | New Patient Consultation/Exam/Treatment | $95.00 |
| _____ | Re-Examination & Treatment | $75.00 |
| _____ | Chiropractic Adjustment/Office Visit | $60.00 |
| _____ | Maintenance or Supportive Care Visit | $60.00 |
| _____ | Laser Treatment | $30.00 |
| _____ | X-Rays | $50-$75.00 |
| _____ | Supplements/Pillows/Ice Pack/Other Supports | $ VARY |
| _____ | Physiotherapy: Flexion-Traction/EMS | $25.00 Medicare Pt. |
| _____ | Massage by the Doctor | $10.00 |
| _____ | Massage by the Massage Therapist | $40 per ½ hour/$80/Hr. |

I acknowledge that I have reviewed my coverage options and benefits and that I have been told in advance of treatment what portion of my care I will have to pay for or possibly have to pay for if my insurance does not cover that service, including non-covered services as described above, and agree to make financial arrangements with my chiropractor, Dr. Jennifer Wells and/or Associates Dr. _____, to pay for these services myself.

For HMO Patients: I acknowledge that this office no longer is accepting any more HMO patient's via ASH Network Plans and I have been told I have the option to seek care by an ASH Network provider, however, I would like to forgo my HMO plan benefits and seek care at this office regardless and self-pay for my services.

Patient Name: _____ Date: _____

Member Signature: _____ Practitioner Signature: _____