CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

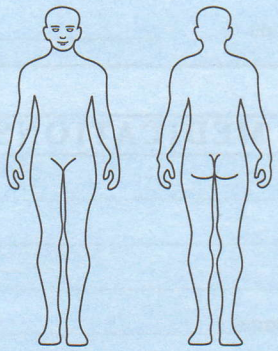
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Other _____	
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No		
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name _____		
Pharmacy Phone (____) _____		

Informed Consent Form

To determine the cause of a patient's presentation and need for and extent of care, the chiropractic doctor will obtain details about the current complaint[s] as well as one's past health history, subsequently perform a physical examination, and in particular cases acquire diagnostic images (such as x-rays or MRI) or laboratory tests.

Chiropractic doctors employ various manually-applied treatment procedures when caring for patients, the most common being an *adjustment*. A chiropractic adjustment involves the application of a quick, precise and usually painless force directed over a very short distance to a specific body part. Adjustments can be performed by hand, by hand-guided instruments, and with the use of specially designed equipment. In addition to adjustments, chiropractors may use other treatment procedures to care for a patient, such as mobilization procedures, physiotherapy modalities (heat, ice, ultrasound, electrical muscle stimulation), soft-tissue manipulation, nutritional recommendations, and supervised exercise and other rehabilitation measures. Neck and back pain are known to generally improve in time, however, recurrence is common. It is also known that keeping a positive attitude and remaining physically active improves one's chances for recovery.

The beneficial effects associated with chiropractic treatment procedures include decreased pain, improved mobility and function, and reduced muscle spasm. There are some conditions for which chiropractic care is contraindicated; other conditions may not respond to chiropractic treatment or perhaps worsen with chiropractic treatment. In these cases, referral to another healthcare provider may be necessary or suggested by the chiropractor.

The body of evidence suggests that chiropractic care is generally safe; however, as with any form of treatment, some risk may be involved. Listed below are summaries of both common and rare side-effects/complications reported to be associated with chiropractic care:

Common [1, 2]

- Reactions most commonly reported are local soreness/discomfort (53%), headaches (12%), tiredness (11%), radiating discomfort (10%), dizziness, the vast majority of which resolve within 48 hours

Rare [3, 4]

- Fractures or joint injuries in isolated cases with underlying physical defects, deformities or pathologies
- Burns due to some physiotherapy procedures
- Disc herniation
- Cauda equina Syndrome (1 case per 100 million adjustments)
- Vertebrobasilar artery stroke (1 case per 400,000 to 1 million cervical spine adjustments [manipulations]). A similar level of association to stroke is found for patients under the age of 45 when consulting with a medical doctor; for those older than age 45, the level of association to stroke is higher when seeing a medical doctor than a chiropractic doctor. ***Please indicate to your doctor if you have a headache or neck pain that is the worst you have every felt. These symptoms may indicate a dissection in progress.***

Alternative forms of treatment that a patient may want to consider before undergoing chiropractic care include *prescription and over-the-counter medications, surgical intervention, and non-treatment*. Listed below are summaries of concerns with these alternative procedures:

- Long-term use or overuse of certain medications carry some risk of dependency; with other medications, long-term use or overuse increases the risk of gastrointestinal bleeding
- Surgical risks may include unsuccessful outcome, complications such as infection, pain, reactions to anesthesia, and prolonged recovery[5]
- Potential risks of refusing or neglecting care may result in increased pain, restricted motion, increased inflammation, and worsening of my condition[6]

1. Thiel HW, Bolton JE, Docherty S, Portlock JC. Safety of chiropractic manipulation of the cervical spine: a prospective national survey. *Spine.* Oct 1 2007;32(21):2375-2378; discussion 2379.

2. Rubinstein SM, Leboeuf-Yde C, Knol DL, de Koekkoek TE, Pfeifle CE, van Tulder MW. The benefits outweigh the risks for patients undergoing chiropractic care for neck pain: a prospective, multicenter, cohort study. *J Manipulative Physiol Ther.* Jul-Aug 2007;30(6):408-418.

3. Cassidy JD, Boyle E, Cote P, et al. Risk of vertebrobasilar stroke and chiropractic care: results of a population-based case-control and case-crossover study. *Spine.* Feb 15 2008;33(4 Suppl):S176-183.

4. Boyle E, Cote P, Grier AR, Cassidy JD. Examining vertebrobasilar artery stroke in two Canadian provinces. *Spine.* Feb 15 2008;33(4 Suppl):S170-175.

5. Carragee EJ, Hurwitz EL, Cheng I, et al. Treatment of neck pain: injections and surgical interventions: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. *Spine.* Feb 15 2008;33(4 Suppl):S153-169.

6. Carroll LJ, Hogg-Johnson S, van der Velde G, et al. Course and prognostic factors for neck pain in the general population: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. *Spine.* Feb 15 2008;33(4 Suppl):S75-82.

Informed Consent Form

Please answer the following questions to help us determine possible risk factors:

QUESTION	YES	NO	DOCTOR COMMENTS
GENERAL			
Have you ever had an adverse (i.e. bad) reaction to or following chiropractic care?	☐	☐	
BONE WEAKNESS			
Have you been diagnosed with osteoporosis?	☐	☐	
Do you take corticosteroids (e.g. prednisone)?	☐	☐	
Have you been diagnosed with a compression fracture(s) of the spine?	☐	☐	
Have you ever been diagnosed with cancer?	☐	☐	
Do you have any metal implants?	☐	☐	
VASCULAR WEAKNESS			
Do you take aspirin or other pain medication on a regular basis?	☐	☐	
If yes, about how much do you take daily? _____			
Do you take warfarin (coumadin), heparin, or other similar "blood thinners"?	☐	☐	
Have you ever been diagnosed with any of the following disorders/diseases?			
• **Rheumatoid arthritis**	☐	☐	
• **Reiter's syndrome, ankylosing spondylitis, or psoriatic arthritis**	☐	☐	
• **Giant cell arteritis (temporal arteritis)**	☐	☐	
• **Osteogenesis imperfecta**	☐	☐	
• **Ligament hypermobility such as with Marfan's disease, Ehlers-Danlos syndrome**	☐	☐	
• **Medial cystic necrosis (cystic mucoid degeneration)**	☐	☐	
• **Bechet's disease**	☐	☐	
• **Fibromuscular dysplasia**	☐	☐	
Have you ever become dizzy or lost consciousness when turning your head?	☐	☐	
SPINAL COMPROMISE OR INSTABILITY			
Have you had spinal surgery?	☐	☐	
If yes, when? _____			
Have you been diagnosed with spinal stenosis?	☐	☐	
Have you been diagnosed with spondyliolithesis?	☐	☐	
Have you had any of the following problems?			
• **Sudden weakness in the arms or legs?**	☐	☐	
• **Numbness in the genital area?**	☐	☐	
• **Recent inability to urinate or lack of control when urinating?**	☐	☐	

I have read the previous information regarding risks of chiropractic care and my doctor has explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.

PATIENT SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE _____ DATE _____

DOCTOR SIGNATURE _____ DATE_____

NOTICE OF PRIVACY PRACTICES
ACKNOWLEGEMENT AND CONSENT FORM

Kyle Bloch, D.C.
8424 Dorsey Circle, Suite 102
Manassas, VA 20110
(703) 368-8800-voice
(703) 368-1282-fax

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers, who may be involved in my treatment directly and indirectly.

- Obtain payment from third party payers.

- Conduct normal healthcare operations such as the business aspect of running the practice on a daily basis.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand I may revoke this consent in writing at any time, except if you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Witness: _____

UNDERSTANDING YOUR INSURANCE COVERAGE

Your insurance policy is an agreement between you and your insurance company. The policy lists a package of medical benefits such as tests, drugs and treatment services. The insurance company agrees to cover the cost of certain benefits listed in your policy. These are called, "covered services."

Your policy also lists the kinds of services that are not covered by your insurance company. You have to pay for any uncovered medical care that you receive. Keep in mind that a medical necessity is not the same as a medical benefit. A medical necessity is something that your doctor has decided is necessary. A medical benefit is something that your insurance plan has agreed to cover. In some cases, your doctor might decide that you need medical care that is not covered by your policy.

Your doctor will try to be familiar with your insurance coverage so he or she can provide you with covered care. However, there are so many different insurance plans that it's not possible for your doctor to know the specific details of each plan. By understanding your insurance coverage, you can help your doctor recommend medical care that is covered in your plan.

> Take the time to read your insurance policy. It's better to know what your insurance company will pay for before you receive a service, get tested or fill a prescription. Some kinds of care may have to be approved by your insurance company before your doctor can provide them. If you still have questions about your coverage, call your insurance company and ask a representative to explain it. Remember that your insurance company, not your doctor, makes decisions about what will be paid for and what will not. Your physician, not your insurance company, makes medical decisions and recommendations about what will benefit your health status.

Most of the things your doctor recommends will be covered by your plan, but some may not. When you have a test or treatment that isn't covered, or you get a prescription filled for a drug that isn't covered, your insurance company won't pay the bill. This is often called "denying a claim." You can still obtain the treatment your doctor recommended, but you will have to pay for it yourself.

If your insurance company denies your claim, you have the right to appeal (challenge) the decision. Before you decide to appeal, know your insurance companies appeal process. This should be discussed in you plan handbook.

AMERICAN SPINE AND SPORT
Dr. Kyle Bloch
8424 Dorsey Circle, Suite 102
Manassas, VA 20110

Patient Financial Policy

We are committed to providing you with the best possible care, and will help you receive your maximum allowable insurance benefits. However, we need *your* assistance and *your* understanding of our payment policy. Your insurance contract is between you, your employer and the insurance company. *(Please refer to the attached document – "Understanding Your Insurance Coverage")* Not all services are covered by all contracts.

We participate and accept assignment from most major payers, which means covered charges, will be paid directly to us. If we do not participate in your insurance plan, you may still choose to be seen by the practice. As a courtesy to you, we will file a claim with your insurance carrier on your behalf. Any remaining balance will be billed to you once we have received remittance from your insurance carrier.

Due to current federal and insurance regulations, *all* co-payments, co-insurance and deductibles are collected at time of service. We accept cash or checks, and for your convenience, Visa, MasterCard and Discover. Additional fees, which typically are not covered by insurance plans will be charged for services such as copying of medical records, and completion of disability forms. A fee of $35.00 will be charged for checks returned for insufficient funds. An additional monthly fee may be charged on all past due accounts and co-pays not paid at time of visit. Delinquent accounts sent to an outside collection agency for further collect efforts will incur an added collection fee. We encourage you to contact us promptly for assistance in management of your account. We are here to help you and will be happy to answer any questions you may have about your treatment or insurance coverage.

Patient Financial Agreement

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read the above Patient Financial Policy and have provided the Practice with true and correct insurance information. I also understand it is my responsibility to notify the Practice of any changes in my health insurance coverage.

A copy of this agreement may be used in place of the original.

_____ _____
Signature of Patient, Policy Holder or Legal Guardian Date

Printed Name: _____