A T L E E C H I R O P R A C T I C C E N T E R

CONFIDENTIAL CASE HISTORY

Please complete this questionnaire in black ink only. Your answers will help us determine how our care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case but will work to refer you to the appropriate health care provider. If you need help with this form, please do not hesitate to ask us.

PERSONAL INFORMATION

Name: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. _____

How do you wish to be addressed in our office? ❑ First Name ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr.

Address: _____ City: _____

State/Zip code: _____ Date of Birth: mm ___ dd ___ yr ___ Marital Status: ❑ Married ❑ Single

Home Telephone: _____ Business Telephone: _____

Cellular Telephone: _____ e-mail address: _____

Employer: _____ Address: _____

Occupation: _____ Hobbies: _____

Spouse's Name: _____ Children's Names: _____

Children's Names: _____ Children's Names: _____

How did you hear about our office? _____

HEALTH INFORMATION

Have you ever been to a chiropractor before? ❑ Yes ❑ No

If so, what was the reason? _____

Have you had previous healthcare for this problem? ❑ Yes ❑ No

If yes, where? _____ When? _____

REASON FOR CONSULTING OUR OFFICE

❑ I have a specific problem and require help only with this problem.

❑ After my specific problem has been relieved, I am interested in strategies to ensure the problem does not return.

❑ After my specific problem has been resolved and I understand methods to ensure it does not return, I am interested in strategies to improve my general health.

❑ I have no symptoms and feel well. I am interested in strategies to help me to continue to feel well, or even better.

What is/are your major complaint(s)? _____

How long have you had this condition? _____

Is this injury: ❑ Work Related? ❑ Motor Vehicle Accident? ❑ Not Applicable

Have you had this or similar conditions in the past? ❑ Yes ❑ No If yes, when? _____

What activities aggravate your condition? _____

What makes it better? _____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

Is this condition interfering with your ❑ Work ❑ Sleep ❑ Daily Routine ❑ Other _____

How long has it been since you really felt well? _____

(Please complete both sides)

List surgical operations and/or major injuries: _____

List any prescription drugs, over the counter drugs, vitamins and natural supplements you currently take: _____

_____

_____

Are you wearing ❑ Heel Lifts ❑ Sole Lifts ❑ Inner soles ❑ Arch support ❑ Orthotics

Have you been in an auto accident: ❑ Never ❑ Recently ❑ Past year ❑ Past 5 years or more

Describe the accident: _____

Have you had any other personal injury or accident: ❑ Never ❑ Recently ❑ Past year ❑ Past 5 years or more

Describe: _____

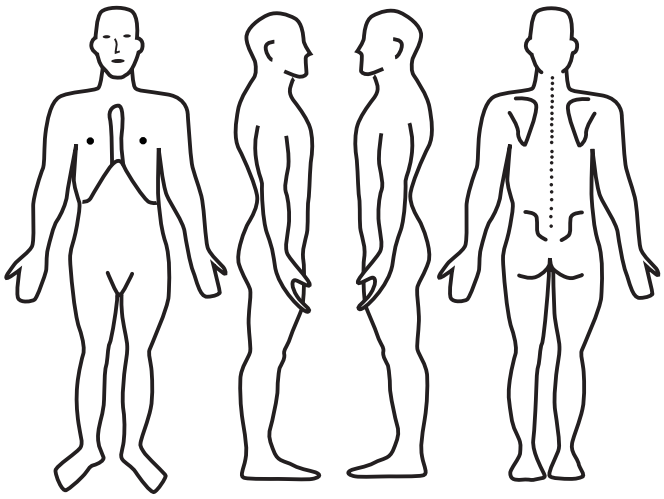
Date of most recent physical examination: _____

Family History:

❑ Anemia	❑ Diabetes	❑ High Blood Pressure	❑ Prostate Problems
❑ Arthritis	❑ Exzema	❑ Hypoglycemia	❑ Psoriasis
❑ Cancer	❑ Emphysema	❑ Lumbago	❑ Rheumatoid Arthritis
❑ Chronic neck pain	❑ Epilepsy	❑ Migraine Headache	❑ Scoliosis
❑ Chronic back pain	❑ Heart Problems	❑ Multiple Sclerosis	❑ Spine Surgery

PLEASE MARK THE AREAS OF PAIN AND/OR DISCOMFORT ON THE FIGURES BELOW:

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?_____

_____

Are you affected by any of the following? Please check: O = Occasionally F = Frequently C = Constantly

	O	F	C		O	F	C		O	F	C
Asthma	❑	❑	❑	Headaches	❑	❑	❑	Heartburn	❑	❑	❑
Backache	❑	❑	❑	Sinus trouble	❑	❑	❑	Migraines	❑	❑	❑
Neck pain	❑	❑	❑	Digestive upset	❑	❑	❑	High blood pressure	❑	❑	❑
Allergy	❑	❑	❑	Constipation	❑	❑	❑	***Females Only*:**			
Earache	❑	❑	❑	Dizziness	❑	❑	❑	Painful menstruation	❑	❑	❑
Sore throat	❑	❑	❑	Shoulder pain	❑	❑	❑	PMS	❑	❑	❑
Foot pain	❑	❑	❑	Leg pain	❑	❑	❑	Are you pregnant?	Y	❑	N ❑

I, the undersigned, having been explained the risks of treatment, do hereby request and consent to the performance of chiropractic treatment and related physical therapy procedures upon the above-named patient (my dependent or myself). I wish to rely on the chiropractor to exercise judgement for my best interest during the course of treatment. I will inform the chiropractor or certified assistant who is treating me of any sensitive areas or adverse conditions I may have had prior to, during, or after treatment. I intend this consent to cover the entire course of treatment.

We thank you for your patience and cooperation in completely filling out this form.

Patient's Signature: _____ Dated: _____

HIPAA Notice of Privacy Practices

Atlee Chiropractic Center
9173 Atlee Road, Mechanicsville, VA 23116
804-730-7010

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 Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office 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, to pay your health care bills, to support the operation 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, your protected health 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 use or 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, employee review, training of medical students, licensing, fundraising, and conducting 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, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under 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 the 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.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date:_____ Attempt:_____

Staff Name:_____

Atlee Chiropractic Center
Payment Agreement

Payment: Your insurance policy requires our office to collect payment for copays and deductible amounts at time of service. Not adhering to these terms could be a violation of our contract with your insurance company and risk reimbursement for services provided. We can accept payment from you in the form of cash, credit card or check (returned checks are subject to a fee.)

Benefits: We verify benefits as a courtesy to you, however, our office does not accept responsibility for any incorrect information given by your insurance carrier regarding coverage and the copays or deductible payments for which you are responsible. As a courtesy, we bill your insurance company for their portion of your billed services. Please feel free to ask us questions once you receive the "Explanation of Benefits" (EOB) from your insurance provider.

A note about maintenance care: Your doctor will determine your initial course of treatment. After you are released from this Active treatment phase, you will be moved to Maintenance. More and more health insurance companies don't see maintenance chiropractic care as medically necessary - *even if you have visits remaining on your plan*. They prefer to only pay for treatments that help people recover from a specific illness, injury or other situation, but not for treatment after someone hits a plateau and stops showing signs of improvement. Once your doctor determines you have reached this phase, usually by performing an exam, our staff can discuss the many options available to you to continue chiropractic care at our office.

Please verify that you understand your financial responsibility by signing and dating below.

Patient Signature: _____

Print Name: _____ Date: _____

Staff Initials: _____

American Specialty Health (ASH)
P. O. Box 509001, San Diego, CA 92150-9001
California Only Fax: 877.427.4777 All Other States Fax: 877.304.2746

PATIENT PROGRESS

Patient completes this form. Chiropractic
For questions, please call ASH at 800.972.4226

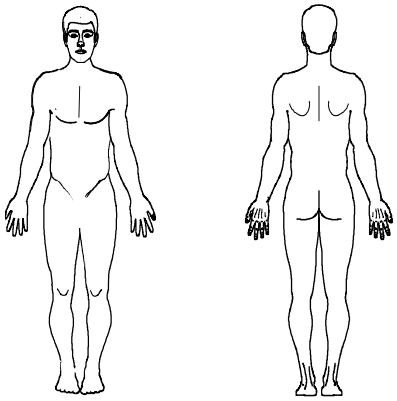
PLEASE PRINT LEGIBLY

Patient Name_____

Please complete the following *three (3)* questions regarding how you feel today.

1. How do you feel today?

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



Current complaint:

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

2. Are you getting better?

Current Condition(s)/Complaint(s) **Rate your overall progress since starting care**

1 _____ _____ % **(0% = No improvement and 100% = Fully recovered)**

2 _____ _____ % **(0% = No improvement and 100% = Fully recovered)**

In the past week, on average how often have your symptoms been present?

☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100%

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

0 1 2 3 4 5 6 7 8 9 10

No interference Unable to carry on any activities

In general would you say your overall health right now is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

3. Is there anything new?

Have you had any new complaints/conditions? ☐ No ☐ Yes

Have you had any re-injuries or events that have prolonged your recovery? ☐ No ☐ Yes

Explain_____

_____

_____

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature_____ **Date**_____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only 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.

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 Index Score _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only 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 _____

*****Frequently asked Questions about Medicare and Chiropractic Coverage*****

According to policies developed by the Center for Medicare and Medicaid Services (CMS), coverage of chiropractic services is "specifically limited to manual manipulation of the spine (also known as a chiropractic adjustment) to correct a subluxation." **Unless this is properly documented, medical necessity cannot be established and claims will be rejected by Medicare**.

The catch-22 for you and your chiropractor is that diagnostic services required to document necessity are not covered. This includes-but is not limited to examinations (initial and progress) and x-rays.

What this means for you, the patient:
Because Medicare only covers chiropractic adjustments deemed medically necessary, our chiropractic doctors must perform an examination, X-rays or sometimes both at the initial New Patient visit to properly document and diagnose medical necessity.

What your course of care may look like:
To determine areas of subluxation, our chiropractic doctors will perform an examination, X-rays and sometimes both at our first appointment. A follow up re-examination/progress check is also performed sometimes between the 6th and 12th visit and at least once a year in order for your doctor to document to our insurance company that there is a medical need for ongoing treatment.

What happens when you care plan is complete:
If it is determined that you have reached maximum therapeutic benefit, Medicare deems your care as maintenance, which is a non-covered service (see below). Maintenance is defined as "a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition." When further clinical improvement cannot be expected from ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is considered maintenance.

It is important to note- you may still receive chiropractic care at this office for maintenance, however, it will not be covered by Medicare or any supplemental insurance. Many of our maintenance patients choose to pay the clinic rate for their treatments or join the nationwide Preferred Chiropractic Doctor (PCD) discount program. At any point should you have another injury, your Medicare insurance will be reinstated and claims for covered services will be submitted.

****What you can expect to pay as determined by your insurance and our clinic rates****

Covered Services
Medically necessary manipulations (Adjustments): After your Medicare annual deductible has been met, you may still be responsible for some portion (co-insurance). Until that deductible is met, the patient is responsible for the full medicare contracted rates for services provided.

Non-Covered Services*
New Patient Exam: $150
X-rays: $85 per region of the spine
Reexamination or Progress Check: $60
Electronic Muscle Stimulation: $25
Maintenance Adjustment: $65 or $70

*PCD program takes 25% off these rates with a $37 annual fee.

*Fees are subject to change. Not all patients require all services. Please refer to your doctor's recommended treatment plan for details.Information has been obtained and adapted from Medicare.gov, ACA.com and CMS.gov