SPECTOR CHIROPRACTIC

Welcome to our Office

We are so glad that you are here today. If you have any questions concerning our policies, forms, or procedures, just ask. It is our pleasure to help you.

Privacy Practices:

I have received a copy of the Notice of Privacy Practices for Spector Chiropractic - _____

patient initials

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed, as well as how you may have access to the information.

We may share your health information to:

- treat you
- collect payment
- run our office
- inform you about other services
- discuss your case with family
- do research
- include you in care classes
- thank you for referring other patients
- As a teaching institution, discuss your case with interns and consult with other colleagues

We may use your health information for:

- health and safety reasons
- reporting to law officials
- reporting victims of abuse
- court hearings and filings
- reporting to worker's compensation
- teaching / Instruction

You have the right to:

- request confidential communications
- request a list of whom we share your health information with
- request a copy of your health record (an additional fee may be involved)
- advise our management if you believe your privacy rights have been violated
- ask us to limit information sharing
- amend your protected health information

_____

patient initials

These privacy practices are effective: January 1, 2011
For further information please contact: Ashley Spector, DC 972-746-0212

Consultation & Exam

To begin today's visit, you will be asked to complete confidential health information for us to discuss with you. To learn more about your condition, we will perform preliminary examinations which may include a physical examination, x-rays, and laboratory tests.

If we believe that we may be able to help you, we will give you a report of our findings and recommend a treatment plan. As you advance through treatment, periodic progress evaluations will measure and compare your improvement. We will always inform you of associated fees before we perform any procedure or service. _____

Office Use Only:

Doctor's Signature # Date

I understand and agree to the above information:

Date

Print Name- patient or guardian

Signature- patient or guardian

6 INSURED'S INFORMATION

last name	first name	m.i.

street	city	state	zip

employer	age	date of birth	social security #	gender
				☐ male ☐ female

Relationship to patient

☐ Self ☐Spouse ☐ Dependent ☐ Other _____

7 BENEFITS ASSIGNMENT & INFORMATION RELEASE

I authorize the payment of charges be made directly to the doctor(s) of this clinic. This authorization includes:

1. All insurance reimbursement for services rendered, including those which may be payable to me under my insurance plan or policy
2. Amounts owed on my behalf from proceeds of any settlement related to my case.

_____

Patient or guardian signature

I authorize the release of any necessary information to my insurance companies, pre-paid health plan or account, or government managed health plan to request payment benefits to me or my assignee.

_____ _____

Patient or guardian signature Date

OFFICE USE ONLY:

Patient: last name	first name	m.i.	date of birth

FILE # **INTERN NAME & #** **DOC #** **POD#**

INSURANCE VERIFICATION

Person's name that you spoke to?
Last: First:
ID # Extension:

Does the plan have a **deductible?** ☐ yes ☐ no
- Amount for an individual: _____
- Amount for the family: _____
- Amount currently met: _____

After deductible, what % of services do you cover? _____
When does the deductible renew? _____

Does the patient have a **co-pay**? ☐ yes ☐ no
- Amount for the co-pay: _____

What is the max. yearly **benefit**? ☐ yes ☐ no
Does the company **assign benefits** to the doctor? ☐ yes ☐ no
What is the **yearly visit cap**? _____
Are any **special forms** required to file claims? ☐ yes ☐ no

Auto Collision or **Personal Injury** case? ☐ yes ☐ no
- Reported to the insurance company? ☐ yes ☐ no
- Has an application for benefits been filed? ☐ yes ☐ no
- Did the police write a report? ☐ yes ☐ no
- Is auto or PI insurance primary? ☐ yes ☐ no
- Agent name and contact info: _____

_____

Workers' Comp case? ☐ yes ☐ no
- Has the injury been reported? ☐ yes ☐ no
  - Name:
  - Title:
- Is patient currently employed at place of injury? ☐ yes ☐ no
- Name of person authorizing care: _____

_____

Does the plan cover the following **services**?

Therptc. Exercise, Therptc. Activity & Neuro Myo Reedu. ☐ yes ☐ no
Chiropractic Adjustments ☐ yes ☐ no
Modalities by a Chiropractor ☐ yes ☐ no
X-rays: _____ ☐ yes ☐ no
Orthotics, supports, pillows and Nutritional supplements? ☐ yes ☐ no
Other: _____ ☐ yes ☐ no

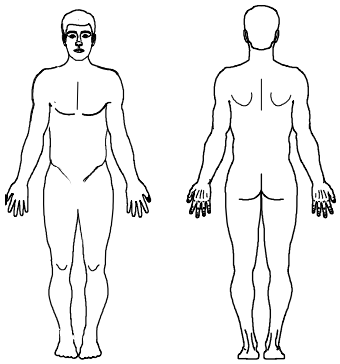
Address to send claims:

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

INITIAL HEALTH STATUS
Chiropractic

Patient Name_____ Birthdate_____ Sex: M / F
Address_____ City_____
State_____ Zip_____ Phone (____)_____ Patient Primary Language_____
Occupation_____ Employer_____ Work Phone_____
Address_____ City_____ State_____ Zip_____
Subscriber Name_____ Health Plan_____
Subscriber ID #_____ Group #_____ Spouse Name_____
Spouse Employer_____ City_____ State_____ Zip_____
Primary Care Physician Name_____ PCP Phone_____

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



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain
☐ Other_____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began_____

How Problem Began

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present?
(Occasional) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

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

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken_____ **What areas were taken?**_____

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)_____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain)_____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks_____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries_____
☐ Tobacco Use - Type_____
Frequency_____/Day
☐ Medications_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature_____ **Date**_____