



COLUMBUS CHIROPRACTIC — CENTER WEST —

4810 West Broad Street Columbus Ohio 43228 PH 614 878 3533 Fax 614 878 3521

New Patient Intake

Name: _____ Age: _____ DOB: _____ Social Security # _____

Address: _____ City: _____ State: _____ Zip Code: _____

Male: ___ Female: ___ Cell Phone: () _____ Email: _____

Employer: _____ Occupation: _____ Work Phone: () _____

Spouse/Insured Name: _____ Birthday: _____ Social Security # _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Single: ___ Married: ___ Divorced: ___ Widowed: ___ Student: ___

How did you hear about us? _____

Welcome to Columbus Chiropractic Center West. Our goals are to address the health concerns that brought you to this office. Today's visit will focus on fixing your presented problems. Following this, we would like to offer you the opportunity to improve your overall health. In order to do this the following questions will need to be answered, as your past history plays an important role in your current health state.

List your chief complaints in order of severity:

1. _____ For how long: _____

2. _____ For how long: _____

3. _____ For how long: _____

What caused your pain? _____

Have you had pain like this before? _____

Does the pain radiate?: _____

Is your pain: (Circle all that apply) Sharp Dull Burning Aching Stabbing Tingling Numb

Is your pain: (Circle all that apply) Constant Frequent Intermittent Occasional Infrequent

Since your problem started, is it (Circle all that apply) About the same Getting better Getting worse

Your pain interferes with: (Circle all that apply) Work Sleep Hobbies Leisure Family life

Other health care providers seen for **this condition**:

Chiropractor: _____

Office Billing Policies

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself, **not between my insurance company and this office**. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, 90 days from initial billing date, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days at 10% yearly APR. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees, collections fees. If my account enters the collection process I will be responsible for any accrued interest, missed appointment fees or file photocopy charges. For balances under \$500 a collection fee of \$50 will be added. For balances over \$500 a 40% collection fee will be added.

Initial: _____

Statements will be mailed at 30,60,90 day with a final notice occurring 10 days post 90 day notice. If no contact is made I understand my account will enter the collection process and be subject to the associated fees stated above.

Initial: _____

Time of service discounts cannot be applied to charges that have been billed or processed by insurance.

Initial: _____

I acknowledge that if I have a future scheduled appointment payment will be due at next date of service. I also understand that I may not receive billing statements via mail so long as I have a future scheduled appointment. I understand my account will enter the billing cycle at either 30,60 or 90 days depending on date of rendered treatment.

Initial: _____

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ____/____/____

Columbus Chiropractic & Physical Therapy Center West
4810 West Broad St
Columbus, Ohio

Patient Name:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare/your insurance doesn't pay for services listed below, you may have to pay. Medicare/your insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare/ your insurance may not pay for the services below.

SERVICES		Reason Medicare May Not Pay:	Estimated Cost
Eval. & Manage Services	99202-99214	NON-COVERED SERVICES	\$60
X-Rays	72040-73100		\$25-\$150
Modalities	97010-97039		\$10-\$25
Therapeutic Proc	97110-97530		\$15-45
Spinal Manipulation	98940-98943		\$30

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the services listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare/ your insurance cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.
<input type="checkbox"/> OPTION 1. I want the services listed above. You may ask to be paid now, but I also want Medicare/ my insurance billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare/ my insurance doesn't pay, I am responsible for payment, but I can appeal to Medicare/My Insurance by following the directions on the MSN or contacting your insurance company. If Medicare/ your insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.
<input type="checkbox"/> OPTION 2. I want the services listed above, but do not bill Medicare/my insurance. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare/my insurance is not billed.
<input type="checkbox"/> OPTION 3. I don't want the services listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare/my insurance would pay.

This notice gives our opinion, not an official Medicare/Insurance decision.

If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Columbus Chiropractic Center West

4810 West Broad St.

Columbus, O.H. 43228

Informed Consent -- Chiropractic Care

Jeffrey C. Covault, D.C. Katherine M. Covault, D.C.

Patient's Name: _____

***Instructions: This document relates to your Informed Consent for care.
Please read carefully before signing.***

General. I, the below-signed patient/individuals, have read this document and Care Plan in their entirety and understand the potential benefits and risks of the Care which you are recommending. I understand that there may be other forms of care which I may wish or need to seek provided by other health care practitioners. I also understand that there may be significant risks of not seeking any care for my condition.

I understand that while the Care Plan lists you as the "Rendering Provider," at any moment, other associates or staff in your office with appropriate scopes of practice and training may need to provide the Recommended Care based on factors which are not necessarily within anyone's ability to predict. You have made it clear that every health care practitioner who is licensed under state law may have different scopes of practice relating diagnoses and treatment and that the licenses of the primary Rendering Provider are listed below.

I do not expect you to be able to anticipate and explain all risks and complications, or forms of treatment, and I wish to rely on you to exercise judgment within your scope of practice during the course of the Care Plan which you feel at the time based upon the facts known. I understand that in rare cases, underlying physical defects, deformities or pathologies may render me susceptible to injury. It is my responsibility to make known before and throughout the Care whether I am suffering from any latent pathological defects, illnesses, or deformities that would otherwise not come to your attention, as well as any pathological defects, illnesses, or deformities I may be experiencing.

Possible Risks of the Care; Alternatives

Chiropractic manipulation / adjustment. As with any healthcare procedure, I understand that there are certain complications, which may arise during chiropractic manipulation, and that those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. 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 treatment. I understand that fractures are rare occurrences and generally result from some underlying weakness of the bone. I also understand that stroke and other complications are also generally described as "rare."

X-Rays. I have been advised that x-rays can be hazardous to an unborn child. To the best of my knowledge. I am not pregnant.

Other Potential Alternatives. I understand that other treatment options for my condition may include: Self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; hospitalization with traction; and surgery.

Contraindications to Manipulation / Adjustment. I understand that you will not give me an adjustment / manipulation, x-rays, modalities, or therapies if you feel that such are contraindicated. In the event that the Care does not include such procedures, I have discussed all contraindications with you and fully understand them.

Definitions. "You" and "office" refer to any provider who renders care to me at the Location above. "Care" includes all care outlined in my Care Plan as well as any other care I receive from you in the future, including care related to other conditions.

Patient's Consent. I have thoroughly discussed and reviewed my recommended Care with you, as well as your examination, diagnoses, and thoughts regarding my condition, and also all of the information in this Informed Consent. I have had ample opportunity to explore other potential forms of care, have asked you all of the questions that I have, and have no additional questions. I voluntarily and knowingly elect to receive the recommended Care.

Patient's Name: _____

Patient's Signature: _____ Date of Signature: __/__/__

Name of Parent / Guardian / Authorized Representative: _____

Signature: _____ Date of Signature: __/__/__

PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information

For the purposes of this Consent Form, "Office" shall refer to Columbus Chiropractic Center West.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name (please print): _____

Signature: _____ 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.

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

Form B1100

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

- ① The pain comes and goes and is very mild.
- ② The pain is mild and does not vary much.
- ③ The pain comes and goes and is moderate.
- ④ The pain is moderate and does not vary much.
- ⑤ The pain comes and goes and is very severe.
- ⑥ The pain is very severe and does not vary much.

Sleeping

- ① I get no pain in bed.
- ② I get pain in bed but it does not prevent me from sleeping well.
- ③ Because of pain my normal sleep is reduced by less than 25%.
- ④ Because of pain my normal sleep is reduced by less than 50%.
- ⑤ Because of pain my normal sleep is reduced by less than 75%.
- ⑥ Pain prevents me from sleeping at all.

Sitting

- ① I can sit in any chair as long as I like.
- ② I can only sit in my favorite chair as long as I like.
- ③ Pain prevents me from sitting more than 1 hour.
- ④ Pain prevents me from sitting more than 1/2 hour.
- ⑤ Pain prevents me from sitting more than 10 minutes.
- ⑥ I avoid sitting because it increases pain immediately.

Standing

- ① I can stand as long as I want without pain.
- ② I have some pain while standing but it does not increase with time.
- ③ I cannot stand for longer than 1 hour without increasing pain.
- ④ I cannot stand for longer than 1/2 hour without increasing pain.
- ⑤ I cannot stand for longer than 10 minutes without increasing pain.
- ⑥ I avoid standing because it increases pain immediately.

Walking

- ① I have no pain while walking.
- ② I have some pain while walking but it doesn't increase with distance.
- ③ I cannot walk more than 1 mile without increasing pain.
- ④ I cannot walk more than 1/2 mile without increasing pain.
- ⑤ I cannot walk more than 1/4 mile without increasing pain.
- ⑥ I cannot walk at all without increasing pain.

Personal Care

- ① I do not have to change my way of washing or dressing in order to avoid pain.
- ② I do not normally change my way of washing or dressing even though it causes some pain.
- ③ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ④ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ⑤ Because of the pain I am unable to do some washing and dressing without help.
- ⑥ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- ① I can lift heavy weights without extra pain.
- ② I can lift heavy weights but it causes extra pain.
- ③ Pain prevents me from lifting heavy weights off the floor.
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ⑤ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑥ I can only lift very light weights.

Traveling

- ① I get no pain while traveling.
- ② I get some pain while traveling but none of my usual forms of travel make it worse.
- ③ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ④ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ⑤ Pain restricts all forms of travel except that done while lying down.
- ⑥ Pain restricts all forms of travel.

Social Life

- ① My social life is normal and gives me no extra pain.
- ② My social life is normal but increases the degree of pain.
- ③ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ④ Pain has restricted my social life and I do not go out very often.
- ⑤ Pain has restricted my social life to my home.
- ⑥ I have hardly any social life because of the pain.

Changing degree of pain

- ① My pain is rapidly getting better.
- ② My pain fluctuates but overall is definitely getting better.
- ③ My pain seems to be getting better but improvement is slow.
- ④ My pain is neither getting better or worse.
- ⑤ My pain is gradually worsening.
- ⑥ 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