BODY IN BALANCE CHIROPRACTIC

feel the difference...

ERIC E. CARSON, D.C.

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501-767-8430 fax

307 N. George St.
Mount Ida, AR 71957
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Acknowledgement of Receipt of Notice of Privacy Practices

NOTICE TO PATIENT- This form will be retained in your medical record.

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of BODY IN BALANCE CHIROPRACTIC.

I understand that the Notice describes the uses and disclosures of my protected health information by BODY IN BALANCE CHIROPRACTIC and informs me of my rights with respect to my protected health information (PHI).

Patient Name:_____ **Date of Birth:**_____

Is it okay to leave messages on your machine/voicemail? _____

Who else may we discuss PHI with on your behalf:

Person's name Relationship

Person's name Relationship

Patient's Signature or that of Legal Representative

Printed Name of Patient or that of Legal Representative

Today's Date

If Legal Representative, Indicate Relationship

FOR OFFICE USE ONLY:

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

Employee Name

Today's Date

CONFIDENTIAL PATIENT INFORMATION

Welcome to our practice!

(PLEASE PRINT) **[CASE #:]**

Name: Date: / /

Address: City, State: Zip:

Phone: Home( ) - Mobile ( ) - Ok to text appt. info? Y or N Carrier:

Email address: Work phone: ( ) -

Birth Date: / / Age: Social Security #: - - Sex: M or F

Marital Status: M S D W Spouse's Name & Work #: ( ) -

Children's Names and Ages:

Favorite Hobbies or Interests: E-mail:

Employed by: Address:

Occupation: Telephone : ( ) - Ext:

Person financially responsible for this bill:

Payment is due at time of service. Method of payment: (check one) ☐Cash ☐Check ☐Credit Card

Who may we thank for referring you?_____

Patient name_____ Date_____ CaseID_____

HEALTH HISTORY

Please list the problems that brought you here in order of severity:

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____

Is this the result of an auto or work injury? ☐Yes ☐No If yes, date of accident/injury: _____

Does the pain spread? ☐Yes ☐No If yes, where? _____

Do you have numbness or tingling? ☐Yes ☐No If yes, where? _____

Is there pain when you cough or sneeze? ☐Yes ☐No If yes, where? _____

Is there pain when you move from sitting to standing? ☐Yes ☐No If yes, where? _____

Do you have headaches? ☐Yes ☐No If yes, circle all that apply: Tension Throbbing Sinus Migraine

Other doctors you have seen for this problem: _____

Operations you have had: _____

Serious illnesses you have had: _____ Broken bones or dislocations: _____

Date of last physical examination: _____ Is there any chance you are pregnant? ☐Yes ☐No

Have you ever been diagnosed with cancer? ☐Yes ☐No If yes, what kind? _____

Medication you currently take: _____

When was your last chiropractic visit?_____ Do you smoke? ☐Yes ☐No If yes, packs per day? _____

Have you had x-rays taken? ☐Yes ☐No If yes, when/what of? _____

Circle the number that corresponds with your CURRENT pain:

No Pain Emergency

0 1 2 3 4 5 6 7 8 9 10

What is your TYPICAL or AVERAGE pain level:

No Pain Emergency

0 1 2 3 4 5 6 7 8 9 10

What is your pain level AT ITS BEST:

No Pain Emergency

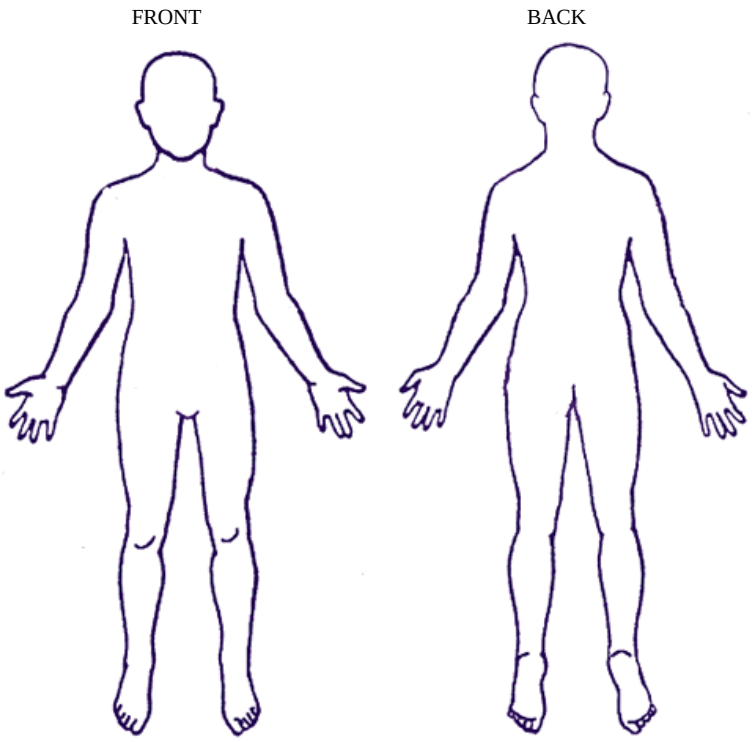
0 1 2 3 4 5 6 7 8 9 10

What is your pain level AT ITS WORST:

No Pain Emergency

0 1 2 3 4 5 6 7 8 9 10

Please circle all areas you have symptoms. Please include all affected areas:



Case ID_____

Neck Score

Oswestry Neck Disability Questionnaire: This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking one box in each section for the statement which best applies to you.

Section 1 – Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is mild at the moment.
- ☐ The pain comes and goes and is moderate
- ☐ The pain moderate and does not vary much.
- ☐ The pain is severe, but comes and goes.
- ☐ The pain is severe and does not vary much.

Section 2 – Personal Care

- ☐ I can look after myself without causing extra pain.
- ☐ I can look after myself normally, but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help, but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get undressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g on a table)
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Reading

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want to with moderate pain in my neck.
- ☐ I cannot read as much as I want to because of moderate pain in my neck.
- ☐ I cannot read as much as I want to because of severe pain in my neck
- ☐ I cannot read at all.

Section 5 – Headache

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

Section 6 – Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Section 7 – Work

- ☐ I can do as much work as I want to.
- ☐ I can do my usual work but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

Section 8 -- Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I cannot drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I cannot drive my car at all.

Section 9 – Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ My sleep is completely disturbed (5-7 hours sleepless).

Section 10 – Recreation

- ☐ I am able to engage in all my recreational activities, with no neck pain at all.
- ☐ I am able to engage in all of my recreational activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- ☐ I am able to engage in only a few of my usual recreational activities because of pain in my neck.
- ☐ I can hardly do any recreational activities because of pain in my neck
- ☐ I cannot do any recreational activities at all.

Patient Signature_____ Date_____

Case ID_____

Back Score

Oswestry Low Back Disability Questionnaire: This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking one box in each section for the statement which best applies to you.

Section 1 – Pain intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2 – Personal care (washing, dressing etc)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of self-care
- ☐ I do not get dressed, I wash with difficulty and stay in bed

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed eg. on a table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

Section 4 – Walking

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 1 mile
- ☐ Pain prevents me from walking more than ½ mile
- ☐ Pain prevents me from walking more than 100 yards
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favourite chair as long as I like
- ☐ Pain prevents me sitting more than one hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

Section 7 – Sleeping

- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

Section 8 –Changing Degree of Pain

- ☐ My pain is rapidly getting better
- ☐ My pain fluctuates but overall is definitely getting better
- ☐ My pain seems to be getting better but improvement is slow
- ☐ My pain is neither getting better or worse
- ☐ My pain is gradually worsening
- ☐ My pain is rapidly worsening

Section 9 – Social life

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests eg, sport
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10 – Travelling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from travelling except to receive treatment

Patient Name_____Date_____

Patient Name_____ Case ID: _____

AUTHORIZATION AND ASSIGNMENT

We offer our patients (in most cases) the courtesy of billing their insurance for them. If you choose to take advantage of this complimentary service, please read and agree to the following:

To Carson Chiropractic, Inc.:

1. You are authorized to **release any information** you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.

2. I authorize and direct the **direct payment to you** of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services. If my current policy prohibits direct payment to doctor, I hereby also instruct and direct the insurance company to make the check to myself and mail the check to Carson Chiropractic, Inc., 1557A Airport Rd., Hot Springs, AR 71913. If my insurance company decides that services are not medically necessary under my health plan, I agree to pay you directly for these services.

3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. I authorize you to complain to the insurance commission on my behalf for any reason. I understand I will be responsible for any attorney and collection fees incurred in attempts to collect from me amounts owed by me. I hereby waive the statute of limitations on collection and/or recovery in this state, Arkansas. I further agree that this Authorization and Assignment is irrevocable until all monies owed Carson Chiropractic, Inc. are paid in full.

4. Insurance companies are legally required to pay or deny a claim within a reasonable time--typically 45 days. I understand that you will allow me a 60 day grace period, that during this time you will follow standard insurance billing procedures in order to secure proper payment from my insurance company. If, for any reason, the claim has not been paid within 60 days, I will make payment at that date.

Date _____ Signature_____