# Balanced Solutions Healthcare

Phone (636) 629-2414 Fax (636) 629-2406

Chiropractic—Acupuncture— Nutrition—N.A.E.T

*Where pain ends...and wellness begins*

**Confidential Patient Information**

Patient's Full Name _____ Date:____/____/____

Primary Phone: _____ Cell Phone: _____ E-Mail: _____

☐ Male ☐ Female Age:_____ Date of Birth:____/___/_____ Social Security # _____ - _____ - _____

Mailing Address:_____ City:_____ State:_____ Zip:_____
☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced Number of Children _____

Occupation:_____ _____Employer:_____ Business Phone_____

Emergency Contact:_____ Relationship:_____ Phone: _____

Family Physician: _____ City: _____ State:_____ Phone_____

Do You Have Health Insurance? _____Company Name_____

Previous Chiropractic Care: ☐ Yes ☐ No If Yes, for what Problem: _____
Doctor's Name _____ City: _____ State: _____

Referred By (Friend, Relative, or Physician) :_____
**Is Today's Visit Due To A Work Related Injury:** ☐ Yes ☐ No
**Is Today's Visit Due To A Personal Injury or Auto Accident:** ☐ Yes ☐ No **Date Of Injury:**_____
(If yes to either questions above, please check with receptionist, additional information is needed)

Person Responsible for Account: _____ Phone: _____
Address:_____ City:_____ State:_____ Zip: _____
Method of Payment Preferred: ☐ Cash ☐ Check ☐ Credit Card

**TODAY'S CHIEF COMPLAINT**_____
Date of Onset: _____ Was the Onset ☐ Gradual ☐ Sudden Since onset, has it gotten: ☐ Worse ☐ Better
Describe what caused the pain:_____

Secondary or related complaint(s) if any:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP EXPLAIN YOUR **CHIEF COMPLAINT:**

Describe the quality of the complaint/pain:
- ☐ sharp
- ☐ dull/ache
- ☐ throbbing
- ☐ tingling/numbness
- ☐ other:_____

Describe if pain is in a single spot or does is spread out:
- ☐ radiating dull, deep ache
- ☐ pin point
- ☐ burning, sharp stabbing, tingling, numb
- ☐ other:_____

How often are you aware of the pain:
- ☐ intermittent (less than 25% of time when awake)
- ☐ occasional (25-50% of time when awake)
- ☐ frequent (50-75% of time when awake)
- ☐ constant (75-100% of time when awake)

Does any of the following make the pain worse:
- ☐ lifting/bending/pushing/pulling
- ☐ cough/sneeze/bowel movement
- ☐ driving/riding/sitting
- ☐ walking/running/standing
- ☐ other:_____

Does any of the following make it better:
- ☐ rest/laying down
- ☐ sitting
- ☐ walking/exercise
- ☐ other:_____

Does it interfere with your daily activities:
- ☐ minimal (annoyance, no impairment)
- ☐ slight (tolerated, some impairment)
- ☐ moderate (marked impairment)
- ☐ marked (preclude any activity)

Have you detected any possible relationship of your current complaint with any of the following:
☐ Muscle Weakness ☐ Bowel/Bladder problems ☐ Digestion ☐ Cardiac/Respiratory ☐ Other:_____

Have you tried any self-treatment or taken any medication (over the counter or prescription): ☐ Yes ☐ No

If yes, explain;_____Results:_____

Are you currently pregnant? ☐ Yes ☐ No Are you currently taking anti-coagulant or blood thinning medication? ☐ Yes ☐ No

In general, what would you say is your perceived overall wellness (Vitality/Health/Energy):_____ **100 is** Excellent **……....0 is** Poor

What type of care are you interested in: ☐ Pain relief only ☐ Healing of current condition ☐ Optimizing your health ☐ All three

In general, would you say your health is (check one): __ Excellent __ Very good __ Fair __ Poor

## PAST HEALTH HISTORY:

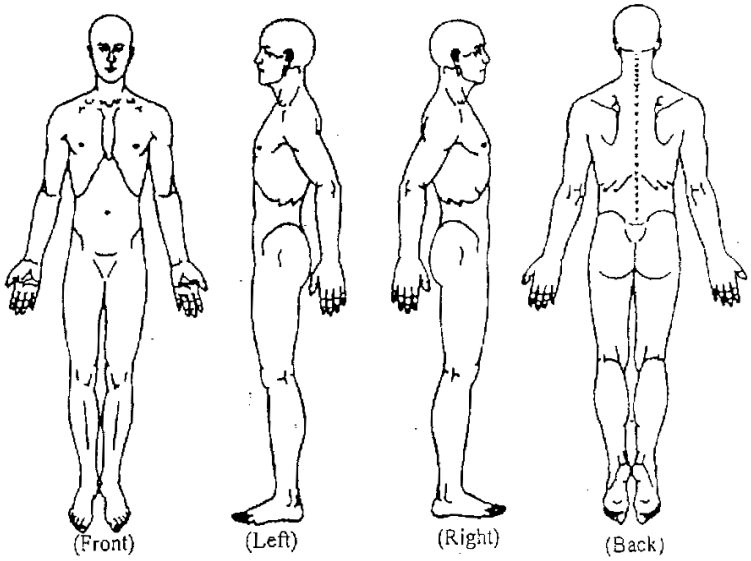
1. Have you ever experienced your present problem before for which you are consulting us: __ Yes __ No
2. If yes, when _____ Was treatment provided: _____
3. Have you **ever** had a **stroke** or issues with **blood clotting**? __ Yes __ No If yes, when _____
4. Have you recently experienced **dizziness, unexplained fatigue, weight loss**, or **blood loss**? __Yes __No
   If yes, please explain _____
5. Please list any **major illness, broken bones, hospitalizations**, or **surgeries** below:

| Date | Injury / fracture / Illness / surgeries | Treatment | Results |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

### PAIN CHART

Please Mark Areas of Pain using these Codes!

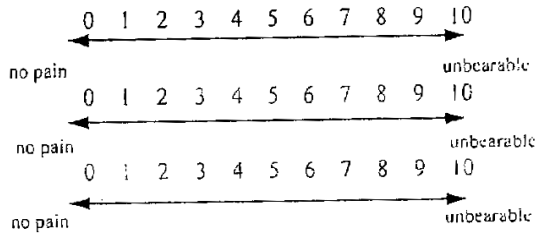
| | |
|---|---|
| +++ | Burning |
| ### | Dull/Ache |
| *** | Numbness/Tingling |
| === | Throbbing |
| 000 | Stabbing/Sharp |




### SEVERITY OF PAIN

List region of pain and circle the number which represents the intensity of your pain.

1. Complaint:_____
2. Complaint:_____
3. Complaint:_____



# INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I_____, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware the there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

**TREATMENT RESULTS**

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

**ALTERNATIVE TREATMENTS AVAILABLE**

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

**I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely**.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ Signature of Patient Date_____

_____Signature of Parent or Guardian (if a minor) Date_____

_____Signature of Witness Date_____

# Coleman Chiropractic P.C.
# Financial / Privacy Policy and Disclaimer

**INSURANCE VERIFICATION**

- **Insurance verification is not a guarantee of payment.** Verification is only a quote benefits. Insurance companies review charges individually and make payment accordingly.
- **Charges not covered by insurance are the patient's responsibility and due within 30 days of billing.** You must comply with your insurance rules such as: a valid referral from your primary care physician, if needed, in order for your claims to be paid at the highest level.
- We will assist you, in processing your referral; however, if a referral is not received to cover all dates of service, you will be responsible for all non-covered or denied charges.

**DEDUCTIBLE PAYMENTS**

**It is our policy to collect at time of service.** Once we receive an "Explanation of Benefits" report from the patient's insurance company, we will bill or credit the account for the remaining balance. Reimbursement checks can be issued upon request.

**COLLECTION OF PATIENT BALANCE**

- Co-Payments and Co-Insurance are the patient's responsibility and will be collected at the time of service.
- If the "Explanation of Benefits" report shows the patient has an outstanding balance from the services not covered by the individual's insurance company, patients will receive a bill outlining these outstanding charges. **Upon receipt, payment is due within 30 days**; **it is the clinic's policy to turn unpaid accounts over to a collection agency.**
- If my account is not paid in full, I understand that I will be required to pay actual cost of collection reasonable attorney, court fees, and 18% interest.

**RETURNED CHECKS**

It is our policy to collect $25.00 for checks that are returned to us. This will cover any fees that apply from the time of the transaction.

**MEDICARE**

Due to the changes with the recent Health Care Reform Act. Our facility has opted out as Medicare providers. Our office will still file your Medicare paperwork if you choose.

**PERSONAL INJURY/AUTO ACCIDENT/WORKER'S COMP.**

If you are dealing with an auto insurance company or involved in a lawsuit that affects the payment of our services, we expect payment within 90 days of your discharge of our office.

There is a **$20 charge for a cancellation or no-show without proper notice.** This charge will not be covered by you insurance, but will have to be paid by you personally.

**When you don't show as scheduled, three people are hurt.**

1) You, because you didn't get the treatment you need as prescribed by your doctor
2) The doctor who now has a hole in their schedule
3) The person that couldn't get in when you had your appointment scheduled.

Coleman Chiropractic P.C. has your permission to list your name on out **Referral Board** and send progress notes to your **Primary Care Physician.**

**HIPPA Notice of Privacy Practices Policy** is posted in the treatment room and copies are available upon request. By signing below, the patient acknowledges that he/she has been informed of the HIPPA Privacy Policy and that he/she understands and will comply with our financial policy.

_____ _____

Patient Signature Date