CHIROPRACTIC ASSOCIATES OF ROCHESTER

Tina Shores, D.C.
Colby Shores, D.C., CCSP
Kevin O'Hagan, D.C.

190 Perrin Drive
Rochester, New York 14622
Phone (585) 544-1540
Fax (585) 544-1580
doctors@chiroroc.com

www.chiroROC.com

PRE EXISTING PATIENTS – PERSONAL INFORMATION UPDATE

NAME: _____DATE: _____

ADDRESS: _____

EMAIL:_____

PHONE NUMBER: (_____)_____-_____ CELL NUMBER (_____)_____-_____

INSURANCE INFORMATION:

INSURANCE COMPANY: _____

SUBSCRIBER ID#:_____

MAIN POLICY HOLDER NAME:_____ DOB :____/____/__

RELATIONSHIP TO POLICY HOLDER: SELF / SPOUSE / CHILD

ASSIGNMENT AND RELEASE:

I, the undersigned certify that I have insurance coverage with the above insurance company and assign directly to Chiropractic Associates of Rochester all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature Date

HEALTH HISTORY:

PRIMARY CARE PHYSICIAN: _____PHONE_____

ARE YOU SEEING ANY OTHER SPECIALISTS? _____

MEDICATIONS:_____

PLEASE DESCRIBE YOUR PRIMARY COMPLAINT:

_____

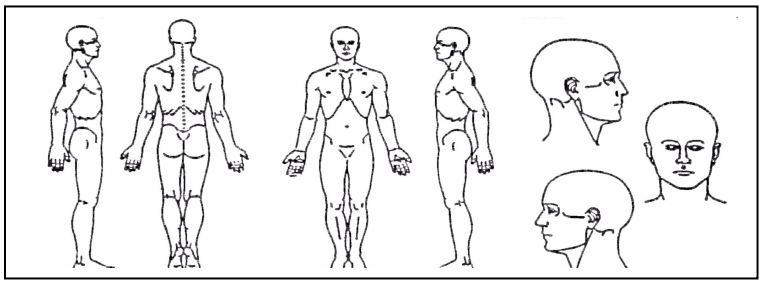
_____

CHIROPRACTIC ASSOCIATES OF ROCHESTER

Patient Name _____ Date_____

☐ Regular ☐ Worker's Comp ☐ No Fault

On the diagram, please indicate the location of pain and the symbol that best describes what you are currently experiencing:



SHARP/STABBING	+++
DULL/ACHY	VVVV
PINS/NEEDLES	0000
NUMBNESS	////
OTHER	XXXX

Type of discomfort: ____ Sharp _____ Dull _____ Aching _____ Burning _____Numbness
(choose all that apply) _____ Tightness _____ Throbbing _____ Diffuse _____Shooting _____Tingling
_____ Other

Frequency of Pain: _____ Constant (100%-75%) _____Frequent (75%-50%) _____ Intermittent (50%-25%) _____ Occasional (25%-0%)

Discomfort increases with: _____Movement _____Applying Pressure _____ Sitting _____Coughing

Discomfort decrease with: _____Rest _____ Movement _____ Medication _____ Ice _____Heat
_____ Chiropractic Care

Region	At WORST	At BEST	TODAY
NECK	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
MID/UPPER BACK	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
LOW BACK	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Other_____	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

Scale: 0=no pain or discomfort 10=most intense pain

-For office use only-

Notes:

_____

_____

_____

_____

	Cervical ROM	Lumbar ROM
Flexion	(90)	(90)
Ext	(70)	(35)
LLF	(40)	(25)
RLF	(40)	(25)
Lrot	(70)	(30)
Rrot	(70)	(30)

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Rochester, NY 14622

The Keele STarT Back Screening Tool

Patient name: _____ Date: _____

Thinking about the **last 2 weeks** pick your response to the following questions:

		Disagree 0	**Agree** 1
1	My back pain has **spread down my leg(s)** at some time in the last 2 weeks	☐	☐
2	I have had pain in the **shoulder** or **neck** at some time in the last 2 weeks	☐	☐
3	I have only **walked short distances** because of my back pain	☐	☐
4	In the last 2 weeks, I have **dressed more slowly** than usual because of back pain	☐	☐
5	It's not really safe for a person with a condition like mine to be physically active	☐	☐
6	**Worrying thoughts** have been going through my mind a lot of the time	☐	☐
7	I feel that **my back pain is terrible** and **it's never going to get any better**	☐	☐
8	In general I have **not enjoyed** all the things I used to enjoy	☐	☐

9. Overall, how **bothersome** has your back pain been in the **last 2 weeks**?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	0	0	1	1

Total score (all 9): _____ Sub Score (Q5-9):_____

CARE PLAN GOALS:

1. Pain Reduction by _____
2. TX Duration_____
3. Improve ROM_____
4. Resume ADL_____
5. Resume Work_____
6. Other GOALS_____

Funded by Arthritis Research UK

Bournemouth Questionnaire
Back Pain (BQ-back)

Name: **Date:**

*Please circle **ONE** number for each of the following statements that best describes your neck pain and how it is affecting you **NOW**. Please read each question carefully before answering:*

1. Over the past few days, on average, how would you rate your back pain?	**No Pain** 0 1 2 3 4 5 6 7 8 9 10 **Worst Possible Pain**
2. Over the past few days, on average, how has your back pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving, sleeping)?	**No Interference** 0 1 2 3 4 5 6 7 8 9 10 **Unable to carry-on with normal day-to-day activities**
3. Over the past few days, on average, how has your back pain interfered with your normal social routine including recreational, social, and family activities?	**No Interference** 0 1 2 3 4 5 6 7 8 9 10 **Unable to participate in any social and recreational activities**
4. Over the past few days, on average, how anxious (uptight, tense, irritable, difficulty in relaxing/concentrating) have you been feeling?	**Not Anxious At All** 0 1 2 3 4 5 6 7 8 9 10 **Extremely Anxious**
5. Over the past few days, on average, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, lethargic) have you been feeling?	**Not Depressed At All** 0 1 2 3 4 5 6 7 8 9 10 **Extremely Depressed**
6. Over the past few days, how do you think your work (both inside the home and/or employed work) has affected your back pain?	**Makes It No Worse** 0 1 2 3 4 5 6 7 8 9 10 **Makes It Very Much Worse**
7. Over the past few days, on average, how much have you been able to control (help/reduce) and cope with your back pain on your own?	**I Can Control My Pain Completely** 0 1 2 3 4 5 6 7 8 9 10 **I Have No Control Whatsoever**

THANK YOU VERY MUCH FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

Source: Bolton JE, Breen AC. The Bournemouth Questionnaire: a short-form comprehensive outcome measure. I. Psychometric properties in back pain patients. J Manipulative Physiol Ther 1999;22(8):503-10.

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OFFICE FINANCIAL AGREEMENT-2022

It is your responsibility to know what your insurance policy covers. Insurance covers acute, medically necessary care. If your insurance denies payment for our services at any time, you agree to take full financial responsibility. Some insurance companies will not allow multiple family members to be treated on the same day in the same office.

Please sign and initial designated insurance line.

_____Excellus BC/BS, Aetna and United
Deduct- Referral may be needed. Until your annual deductible is met the office fee will be procedure dependent. Fee is due at time of service. Once the deductible is met, you will be responsible for co-insurance policy dependent. Supplements, orthotics, supports, etc. are not covered.
Co-Pay- Referral may be needed. Your co-pay is due at the time of service and will range from $10-$60 depending upon your contract. Supplements, orthotics, cushion are not covered and are the patient's responsi Blues cover **acute care** and not maintenance care.

_____ Medicare Advantage Plans: Aetna/BCBS/MVP Gold/United
PCP referral is required. Primary care physician sets number of visits allowed. Should your carrier or PCP fail to supply authorization, you will be responsible for the usual and customary fee (ABN).

____Medicare: No referral needed. Until your annual estimated Deductible of $233.00 is met the office fee is $40.00 - $90.00. You will be responsible for any usual and customary fee (ABN)

_____MVP/CIGNA/OTHER*:* The doctors in this office are out of network providers. Initial consultation fee, history and examination is $80.00. Subsequent visits thereafter are $40.00. Depending on your contract you may have out of **network coverage**. We will supply you with a claim form so that you can submit to your insurance company.

____Usual & Customary Office Fees: First visit for consultation, history and examination is $80.00. Subsequent visits thereafter are $40.00. Initial Spinal scan fee included in $80.00 charge.

Rock Tape (Kinesio Tape):
__ **Option 1: Free application with purchase of roll (for life of roll)**
__ **Option 2: $5.00 charge per region application**

_____ Worker's Compensation: If you require treatment for an injury that occurred while performing your normal employment, you may be eligible for 100% coverage by your employer's worker's compensation insurance. In such cases, to ensure your coverage, it is your responsibility to report your injury to your employer in writing and fill out the appropriate reports. Failure to do so will jeopardize your coverage. Should your case be denied you would become liable for services rendered. **Mileage sheets will be available for $20.**

_____Auto Accidents/No Fault Insurance: If you are seeking treatment because of an auto accident, you may be eligible for 100% coverage by your No-Fault Insurance. Some companies have a deductible that must be met first. It is your responsibility to contact your insurance company and fill out the appropriate reports. Should your insurance decline to pay for your case, you would become liable for all services rendered. **Mileage sheets will be available for $20.00**

_____ Maintenance Care: Elective healthcare defined as patient has achieved and maintained pre-complaint status, plateaued in improvement, and/or chronic symptoms show no progression in reduction or remain stable. Treatment intervals are at regular intervals (example: 1 time a week, every 2 weeks, every 4 weeks, etc.) Benefits of maintenance care include enhanced quality of life, improved health, prevention of future injury. This is a service not covered by the insurance company and you will be responsible for the office fee of $40. If you sustain a future incident or injury, your chiropractic care would again meet the criteria for acute care and would be covered by your health plan until that condition has achieved pre complaint status or plateaued in improvement.

There may be additional services/products needed to supplement your care.

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Chiropractic Associates of Rochester all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

- **Please note that our office does not allow a personal balance over $100 (unless other financial arrangements have been made in writing). Should your account become 60 days delinquent a $10 charge per month will be assessed to the outstanding balance.**
- **Payment is due at the time of service. Payment in the form of cash, check, HSA, Credit Card is accepted.**
- **Returned Checks will have a $25 service charge.**

_____

Responsible Party Signature **Date**

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AUTHORIZATION FOR RELEASE OF INFORMATION:

TO: _____

_____

_____

SPECIFIC DESCRIPTION OF INFORMATION TO BE DISCLOSED:

_____ Medical Records regarding _____

_____ X-Rays and / or report of findings, CT Scans, MRI's

_____ Consult reports from specialists

_____ Test Results

_____ Billing Records

_____ Other _____

I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by Federal privacy regulations.

Initials _____

I understand that this authorization is voluntary and that I may revoke it at anytime by submitting my revocation in writing to the entity providing the information. The revocation will only be effective from the date the written revocation is provided and will not apply retroactively.

Initials _____

I understand that this authorization will expire one (1) year from the date of the original signature indicated below.

Initials _____

Patient Name: _____

Date of Birth: _____

Signature of Patient _____Date: _____

If under age 18 Signature of Guardian: _____Date: _____

Relationship to Patient: _____