Patient Information

Patient Name: _____ **Date:** _____

Address: _____

Email Address: _____

Home #: (____) ____-_____ **Cell #:** (____) ____-_____

Sex: M F **Age:** _____ **Date of Birth:** ___/___/_____

Emergency Contact (Name, Relationship, Phone #): _____

Occupation: _____ Whom may we thank for referring you? _____

Family Health History: _____

_____

Primary Care Physician: _____

Patient Condition

Reason for your visit? _____

When did it begin? _____ What do you think was the cause? _____

What makes it better? _____ Worse? _____

Rate the severity of the pain on a scale of 0 (no pain) to 10 (excruciating pain) 0 1 2 3 4 5 6 7 8 9 10

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting Burning
Tingling Cramping Stiffness Swelling Other _____

Does this pain interfere with your Work Sleep Daily Routine Hobby/Recreation

Previous history of primary complaint? _____

StemWave Consent Form

By answering the following questions, you will assist our team in identifying if you are qualified to receive the application of today's treatment.

Areas of concern you would like addressed and treated:_____

Describe type of pain/feeling in the concerned area:_____

What goals do you want to accomplish with treatment? _____

Are you pregnant? Yes ☐ No ☐

Do you have cancer/tumor or a skin infection? Yes ☐ No ☐

Are you UNDER the age of 16? Yes ☐ No ☐

Do you have a tear in the tendon? Yes ☐ No ☐

Do you have a cardiac pacemaker? Yes ☐ No ☐

Do you have a bleeding disorder/tendency to bleed? Yes ☐ No ☐

Are you on NSAIDS, OPIOIDS or anti-coagulant treatment? Yes ☐ No ☐

Have you received a cortisone injection within the last 30 days? Yes ☐ No ☐

Have you had any imaging (X-Rays, MRIs) done on the area of concern? Yes ☐ No ☐

→ if yes, what did you have done and where?_____

Medications:_____

Medical History:_____

Surgery History:_____

Accidents/Trauma:_____

RISKS OF PROCEDURE: There may be temporary pain &/or soreness. This typically resolves within hours or 1-2 days.

I, _____, (circle one: Patient / Legal Guardian) do hereby consent to authorize the application of today's treatment for the above stated issues. I fully understand the nature of today's treatment/procedure. I have researched the treatment option &/or the treatment has been fully explained to me by the treating physician/staff. I confirm that upon entering the facility I have been provided the opportunity to have a discussion to clarify any concerns I may have. I authorize that guaranteed results/expectations have not been promised to me. I also understand I am forgoing the opportunity for alternative &/or medical treatments and opting to have today's treatment per my personal discretion.

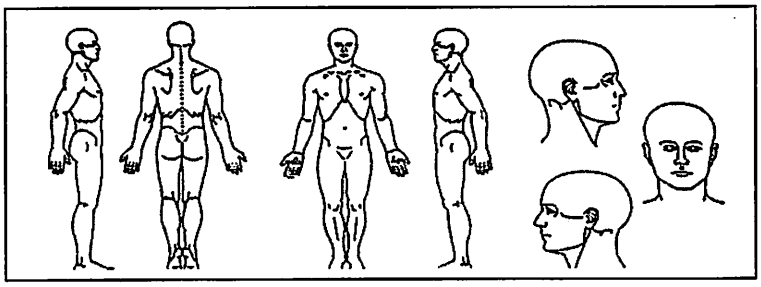
Signature: _____ **Date:**_____

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: (choose all that apply) ____ Sharp ____ Dull ____ Aching ____ Burning ____ Numbness ____ 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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OFFICE FINANCIAL AGREEMENT-2024

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- Your co-pay is due at the time of service and will range from $10-$70 depending upon your contract. Supplements, orthotics, cushion are not covered and are the patient's responsibility. Blues cover **acute care** and not maintenance care.

_____ **Medicare Advantage Plans: Aetna/BCBS/MVP Gold/United**
Authorization is required on some Ins. Your insurance sets number of visits allowed. There are some costs that are out of pocket per Medicare. Please refer to the ABN agreement. Your insurance covers acute care not maintenance care.

____**Medicare:** No referral needed. Until your annual estimated Deductible of $240.00 is met the office fee is $40.00 - $80.00. You will be responsible for any usual and customary fee (ABN)

_____**MVP/CIGNA/OTHER*: T***he 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**

CHIROPRACTIC ASSOCIATES OF ROCHESTER

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

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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: _____