

Chiropractic Case History/Patient Information

Date: _____ Patient # _____ Chiropractor: Rowena M. de Jesus, D.C.
 Gregory Petruzzi, D.C.

Name: _____ Social Security # _____ Home Phone: _____

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

E-mail address: _____ Fax # _____ Cell Phone: _____

Age: _____ Birth Date: _____ Marital: M S W D

Occupation: _____ Employer: _____

Employer's Address: _____ Office Phone: _____

Spouse: _____ Occupation: _____ Employer: _____

How many children? _____ Names and Ages of Children: _____

Name of Nearest Relative: _____ Address: _____ Phone: _____

Referral: Standard Speaker _____ Panorama _____ Valley View _____ Other _____

Family Medical Doctor: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____

Is this due to: Auto _____ Work _____ Other _____

Have you ever had the same or a similar condition? Yes No If yes, when and describe: _____

Days lost from work: _____ Date of last physical examination: _____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

<input type="checkbox"/> Broken or Fractured Bones	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Pace Maker	<input type="checkbox"/> Drug Addiction
<input type="checkbox"/> Seizures/Convulsions	<input type="checkbox"/> Strokes	<input type="checkbox"/> HIV Positive
<input type="checkbox"/> A Congenital Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Gall Bladder
<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Ruptures	<input type="checkbox"/> Depression
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Coughing Blood	<input type="checkbox"/> Ulcers

Do you have a history of stroke or hypertension? _____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe: _____

What medications or drugs are you taking? _____

Please list any other health problems you have, no matter how insignificant they may be: _____

SOCIAL HISTORY:

Do you drink alcoholic beverages? ___ If so, how much per week? _____
Do you use any tobacco products? ___ Do you smoke? ___ If so, packs per day: _____
Do you take vitamin supplements? ___ If so, please list: _____
Do you consume caffeine? ___ If so, how much per day: _____
Do you exercise? ___ If yes, what is the frequency and type of exercise? _____
What are your hobbies? _____
What percentage of time during the day (at home or at your job away from home) do you spend:
lifting ___ sitting ___ bending ___ working at a computer _____

FAMILY HISTORY:

Parents:
Father: living ___ deceased ___ Current age if still living: ___ Cause of death and age at death if
deceased: _____ (check one)
Mother: living ___ deceased ___ Current age if still living: ___ Cause of death and age at death if
deceased: _____ (check one)

Check if applicable to you: ___ As an adopted child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do? If so, please
list: _____

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

Tuberculosis ___ Cancer ___ Mental Illness ___
Diabetes ___ Asthma ___ Heart Disease ___
Stroke ___ Kidney Disease ___ Lung Disease ___
Arthritis ___ Liver Disease ___
Other _____

Please check any and all insurance coverage that may be applicable in this case:

- Highmark Blue Shield Major Medical Worker's Compensation Medicare Auto Accident
- Medical Savings Account & Flex Plans Other _____

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

SUMMARY

1. What is your major symptom? _____
2. What does this prevent you from doing or enjoying? _____
3. If this is a recurrence, when was the first time you noticed this problem? _____
 How did it originally occur? _____
 Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse ___
 If yes, when and how? _____
4. How frequent is the condition? Constant ___ Daily ___ Intermittent ___ Night Only ___
 How long does it last? All Day ___ Few Hours ___ Minutes _____
5. Are there any other conditions or symptoms that may be related to your major symptom?
 Yes ___ No _____. If yes, describe: _____
 Are there other unrelated health problems? Yes ___ No _____. If yes, describe _____

6. Describe the pain: Sharp ___ Dull ___ Numbness ___ Tingling ___ Aching ___
 Burning ___ Stabbing ___ Other _____
7. Is there anything you can do to relieve the problem? Yes ___ No _____. If yes, describe _____
 _____. If no, what have you tried to do that has not helped? _____

8. What makes the problem worse? Standing ___ Sitting ___ Lying ___ Bending ___
 Lifting ___ Twisting ___ Other _____
9. List any major accidents you have had other than those that might be mentioned above: _____

10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
 Yes ___ No ___ Uncertain _____
11. Remarks: _____

NO SYMPTOMS

EXTREME SYMPTOMS

Please place an "X" on the line above to indicate level of problem.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

Chiropractor's Signature _____ Date _____

De Jesus Family Chiropractic

Located at

Life Expression Wellness Center

298 Rock Glen Road
Sugarloaf, PA 18249-3211

Phone: 570-708-2228 • Fax: 570-708-2039

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. The chiropractic objective is to allow correction of nerve interference to the central nerve system so that the body's innate ability to heal and express best life expression could be allowed. Following are some chiropractic terms that you will learn with your chiropractic care at our office.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential through a lifetime.

Meninges: Three structural membranes that cover and protect the brain and spinal cord. They also sheath and protect each cranial and spinal nerve root and suspend inside the brain for internal protection.

Adjustment: An adjustment is the specific application of gentle forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine and balance of the meninges.

We do not offer to diagnose or treat any disease or condition other than correction of the vertebral subluxations and balance of the meninges. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we recommend that you seek the services of a health care provider who specializes in that area. Regardless of what your disease or condition is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR CHIROPRACTIC OBJECTIVE** is to allow correction of nerve interference to the expression of the body's innate healing. Our only method is specific adjusting to correct vertebral subluxations and balance of the meninges.

In signing, I am accepting chiropractic care, from any attending chiropractor from Dr. Rowena M. de Jesus Family Chiropractic, for myself or the specified patient/minor named below.

Patient Name (PLEASE PRINT)

Signature of patient, parent, or guardian

Date _____

De Jesus Family Chiropractic

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. I understand that, and give consent to, the following appointment reminders that may be used: a postcard being mailed to me at the address I have provided and/or a telephone message being left either directly with me, on my answering machine or voice mail, or with the individual answering the telephone. I understand that other practice members will view my signature on a sign-in sheet.
2. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
3. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
4. I authorize the use of this form as a release of records to my insurance company(s) and/or legal representation. This authorization includes the disclosure of my medical history, findings, consultations, chiropractic care, x-rays, reports, chiropractic analysis and chiropractic prognosis.
5. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
6. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
7. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
8. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
9. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

NAME OF PATIENT

DATE

PATIENT'S SIGNATURE (Parent or legal guardian if minor)

RELATIONSHIP

De Jesus Family Chiropractic
298 Rock Glen Road • Sugarloaf, PA 18249
Phone: 570-708-2228 • Fax: 570-708-2039

FINANCIAL POLICY

Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we will suggest the chiropractic care you need. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE

We require that 100% of all services be paid at the time they are incurred. We are happy to accept cash, personal check, VISA, MasterCard, and/or Discover.

GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify your benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. It is to be understood and agreed that any services rendered are to be charged to you directly and you are personally responsible for payment of any covered and/or non-covered services, deductibles, and/or co-pays. Once services are paid in full, we will furnish you with a statement containing all information needed for you to submit to your insurance carrier for reimbursement. Any reimbursements you may be eligible for should be sent directly to you by your insurance carrier. In the event that a check comes to us inadvertently, one of two situations may occur: The check may be returned to the insurance carrier to be reissued to you directly, or the check may be posted to your account as a credit toward future services.

“ON THE JOB” INJURY (WORKER’S COMPENSATION)

If you are injured on the job, your care should be paid for under your employer’s Worker’s Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of their insurance. If your employer does not provide us with this information, if a settlement has not been made within three months, or if you suspend or terminate care, any fees and services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card, your health insurance card, and tell us if you have obtained an attorney. There are three options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor’s Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

MEDICARE

We do not participate in Medicare, nor do we accept assignment from Medicare. The check is sent directly to you for payment of services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare normally pays 80% of the allowable fee once the deductible has been met. ALL OTHER SERVICES WE PROVIDE ARE NOT COVERED. These services include, but are not limited to, x-rays, examinations, therapies, modalities, supplies, and/or nutritional supplements. Medicare patients are fully responsible for all charges of covered and non-covered services. Our office, as a courtesy completes and files forms for Medicare at no charge. Medicare is responsible for crossing over and forms to your secondary insurance carrier. Please make sure you call Medicare and set this crossover up with them.

MANAGED CARE PLANS

We are participating providers with Highmark Traditional Blue Shield, and Premier Blues which include Access Care II, FEP, and Blue Card. Patients with Traditional Blue Shield are required to pay for services up front, obtain a statement for filing from us and their Major Medical department, and submit claims on their own. Checks for reimbursement are sent directly to the patient. Other plans will be verified by our office, and paid as each particular plan states. You will be responsible for any non-covered services and/or supplies, deductibles and/or co-pays at the time of service. In some instances, co-pays are due per visit, in other cases, they are due per service. Please be sure to be aware which of these your policy states.

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request for more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by your insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it represents payment of your bill here.

I have read and understand the payment policy for De Jesus Family Chiropractic I understand that my insurance is an arrangement between myself and my insurance company, NOT between De Jesus Family Chiropractic and my insurance company. I also understand that if my insurance company does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed, that fees will be due and payable immediately.

Patient’s Name: (Please print) _____

Patient’s Signature (or guardian if patient is a minor): _____ Date: _____

Witness Signature: _____ Date: _____