HEALING HANDS
CHIROPRACTIC

Damien Rodulfo, D.C., C.C.S.P.

Patient Information

Full Name: _____ Date: _____/_____/_____

Preferred Name: _____ Date of Birth: _____/_____/_____

Street Address: _____ □ Female □ Male

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Type (Please Circle): Home Cell Work

Secondary Phone: _____ Type (Please Circle): Home Cell Work

Email Address: _____

Emergency Contact: _____ Phone: _____

Are you current or retired military personnel or a current first responder (Fire, Law Enforcement, EMS)? □ Yes □ No

Referral Information

How did you hear about our office? Please circle one of the following, and name the source in the space provided.

Physician Current Patient Attorney Family/Friend Crossfit/Gym Health Fair/Race

Google Yelp Other Internet Source

_____

Consent for Treatment

Assignment and Release: By signing below, I authorize Healing Hands Chiropractic to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Healing Hands Chiropractic, and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.

By signing below, I give my consent for examination and the performance of any test or procedures needed. If patient is a minor, by signing I give consent for examination, tests, and procedures for the above minor patient.

Signature: _____ Date: _____/_____/_____

Name: _____

Please check the box if you have had any of these conditions:

◯ AIDS/HIV	◯ Cancer	◯ High Cholesterol	◯ Parkinson's Disease
◯ Alcoholism	◯ Chest Pain	◯ Implant	◯ Pinched Nerve
◯ Allergy Shots	◯ Depression	◯ Kidney Disease	◯ Pneumothorax
◯ Anemia	◯ Diabetes	◯ Liver Damage	◯ Polio
◯ Appendicitis	◯ Digestive Problems	◯ Loss of Balance	◯ Prostate Problems
◯ Arthritis	◯ Dizziness	◯ Lung Problems	◯ Rheumatoid Arthritis
◯ Asthma	◯ Epilepsy	◯ Migraine Headaches	◯ Ringing in the Ears
◯ Bleeding Disorder	◯ Glaucoma	◯ Multiple Sclerosis	◯ Stroke
◯ Blurred Vision	◯ Heart Disease	◯ Osteoporosis	◯ Thyroid Problems
◯ Breast Lump	◯ Hepatitis	◯ Pacemaker/Stimulator	◯ Tumors

◯ Other: _____

Current Medical Doctors/Alternative Doctors: _____

Surgeries: _____

Illnesses/Injuries/Hospitalizations: _____

Medications: _____

Vitamins/Supplements: _____

Allergies: _____

Typical Foods Eaten: _____

Are you pregnant? ◯ Yes ◯ No Due Date: _____

Tobacco: ◯ Cigarettes ◯ Cigars ◯ Pipe ◯ Smokeless **How often?** ◯ Daily ◯ Weekends ◯ Occasionally ◯ Never

Alcohol: consumption occurs ◯ Daily ◯ Weekends ◯ Occasionally ◯ Never

Recreational Drug Use: ◯ Daily ◯ Weekends ◯ Occasionally ◯ Never

Exercise: ◯ Daily ◯ 2-3 times per week ◯ 1 time per week ◯ Never

Name: _____

Please describe the reason for your visit: _____

_____

_____

Date symptoms began: _____/_____/_____ **Date of most recent flare-up:** _____/_____/_____

If this is an injury, how did the injury occur? _____

Symptom frequency (circle one): 25% or less 26%-50% 51%-75% 76%-100% **Of The** (circle one) Day Week Month

Symptom Timing (circle one of the following and indicate same, better, or worse)

Same all day Better/Worse in the morning Better/Worse at midday

Better/Worse at end of the day Better/Worse at night

Describe your pain or discomfort. Please select all that apply.

Dull	Sharp	Throbbing	Burning	Deep	Aching
Tingling	Stabbing	Cramping	Numbness	Radiating	Stiffness

Describe which activities worsen your pain or discomfort. Please select all that apply.

Sitting	Standing	Walking	Bending	Stooping	Lifting
Sleeping	Sneezing	Coughing	Straining	Reaching	Twisting
Looking Up	Looking Down	Movement	Rest	Lying Face Up	Driving
Typing	Scooping	House Chores	Exercise	Lying Face Down	Stair Stepping

Describe which activities relieve your pain or discomfort. Please select all that apply.

Sitting	Standing	Lying	Knees Bent Up	Support
No Movement	Movement	Heat	Ice	Analgesic Topical
Ibuprofen	Medication	Rest	Stretching/Exercise	Adjustments

Where applicable, specify the approximate date of your most recent exams (month/day):

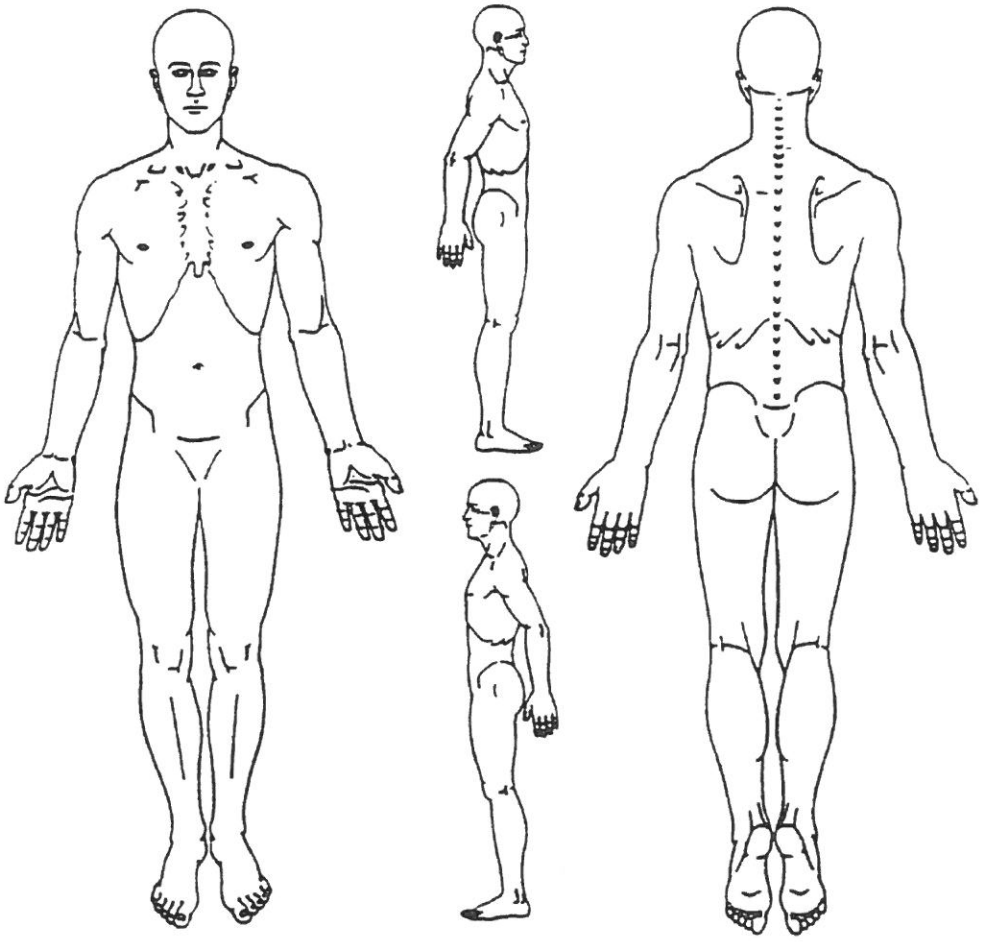
Physical Exam: _____/_____ Dental X-Ray: _____/_____

Spinal X-Ray: _____/_____ CT Scan: _____/_____

MRI: _____/_____ Other Scans or X-Rays: _____/_____

Name: _____

Please indicate your areas of discomfort or pain by marking the affected body parts in the illustration.



Indicate the area name in the chart below. Rate your discomfort or pain associated with each selected area.

Ex.	(L)	R	Lower Back	0	1	2	3	4	5	6	(7)	8	9	10
1.	L	R	_____	0	1	2	3	4	5	6	7	8	9	10
2.	L	R	_____	0	1	2	3	4	5	6	7	8	9	10
3.	L	R	_____	0	1	2	3	4	5	6	7	8	9	10
4.	L	R	_____	0	1	2	3	4	5	6	7	8	9	10
5.	L	R	_____	0	1	2	3	4	5	6	7	8	9	10

Authorizations and Releases

Name: _____

Consent to Professional Treatment

I certify that all information provided to this practice is true and correct to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care of treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am a legal guardian of the child, and grant my consent for a treatment of the child as provided for herein. I acknowledge that I may refuse treatment at any time.

Initial: _____

Consent to Perform and Interpret X-Rays

I hereby consent to the performance of diagnostic x-rays as deemed necessary by the attending physician of this practice and acknowledge that certain risks are associated with x-rays. If applicable, I certify that I am a parent or legal guardian of the patient, and I hereby authorize the performance of diagnostic x-rays on said minor as requested by the physician. At this time, I know of no condition which the taking of x-rays would further complicate.

I further agree that this practice may seek outside interpretation of my x-rays by a qualified professional not employed by this practice. I agree that any additional fees associated with this service and assigns benefits to be paid directly to that professional by my third-party payor.

Initial: _____

Females: Consent to X-Ray During Pregnancy

This is to certify that I am or may be pregnant and that a doctor or certified staff have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis can be hazardous to a fetus.

Initial: _____

Assignment of Benefits and Release of Records

I hereby assign to this practice all of my medical and procedure benefits to which I am entitled, including major medical benefits. I hereby authorize and direct my insurance carrier(s), including Medicare and other government sponsored programs if applicable, private insurance and any other health care plans to issue payment directly to this practice for medical services rendered. This assignment is irrevocable.

I hereby authorize this practice to release any medical or other information required by third party payors, including government agencies, insurance carriers, or any other entities necessary to determine insurance benefits or benefits payable for related services and supplies provided to me by the practice.

Initial: _____

Financial Obligations

I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any incurred, regardless of insurance coverage. I understand that my insurance carrier may not approve or reimburse my medical services in full due to customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where in my liability is limited by contract of State or Federal law. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim.

Should the account be referred to an attorney for collection, I shall pay fees, including, but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. It is my responsibility to notify this practice of any changes in my health coverage.

You may direct any questions regarding this financial obligation to the clinic manager or physician.

Initial: _____

Signature: _____ Date: _____/_____/_____

Notice to UNITED HEALTHCARE, COVENTRY, UMR, BCBS Centivo,

MEDICARE, and MEDICAID Patients

Name: _____

Due to changes in the fee schedules of these carriers, we must now charge for Active Release Techniques (ART) performed by our providers at a cost of $30 per visit. This is a non-covered charge under the insurance companies listed above. ART is a patented movement based soft tissue mobilization and stretching system in which we specialize. Dr. Rodulfo and our providers have always done ART as part of treatments but did not have to charge you separately for this service until the recent insurance changes. Below is an estimated cost per visit based on the guidelines of your health insurance policy. If you have any questions, please speak with the front desk staff. As always, we appreciate you being a part of our practice. Thank you in advance for your understanding. Policy is effective 1/3/17 and subject to change.

AETNA, UNITED HEALTHCARE, COVENTRY, UMR

Cost per visit = Your Copay +$30 ART fee (e.g. $25 Copay + $30 ART fee = $55 per visit)
OR
Deductible = $85.00 per visit

MEDICARE

With Supplement = $30 ART fee per visit
OR
Without Supplement = $30 ART fee + 20% Coinsurance

MEDICAID

$3 Copay + $30 ART fee = $33 per visit

Even if I am not currently filing one of these listed insurances, I acknowledge that have read and understand this policy and have had the opportunity to ask questions.

Signature: _____ Date: _____/_____/_____

Patient Waiver for Non-Covered Services

Name: _____

Your insurance does not pay for all your health care costs. Some items and services are not considered "covered benefits" under your health insurance plan and as such, your insurance will not pay for these services.

Your physician believes that the following services, although not covered by your health insurance, are an important part of chiropractic care and may recommend that you receive these services as part of your current treatment plan. However, since the services listed here are not considered to be a covered benefit under your health insurance, should you choose to receive these services, you will be personally responsible for the payment of such services. The purpose of this notice is to help you make an informed choice about supplemental services.

The services recommended by your physician are listed below:

Taping	$15 for one time or $20 for box
Laser Therapy/Piezo Wave	$15 with chiropractic treatment $50 as a standalone treatment
Dry Needling or Acupuncture	Variable based on appointment length
Electrode Pads	$10
Labs/Blood Work	Variable based on test
Supplements	Variable based on supplement
GSO Cryo Services	Variable based on service
Durable Medical Equipment	Variable based on product
Orthotics	Variable based on product
No Show Fee	$25 if notice not given 24 hours before appointment

I acknowledge that I have been informed in advance of receiving these services and that these services are not covered by my health insurance plan. I have chosen to receive these services and understand that I will be financially responsible for the charges indicated above.

Signature: _____ Date: _____/_____/_____