Optimal Healthcare Physical Medicine

Health Questionnaire

Name: ______________________ Age____ DOB__________ Home Phone #: ______________

Address: ______________________________ City: ________________ State ____ Zip: ______

Occupation: ________________________ # Hours/Week Currently Working: ________________

E-mail Address: ________________________________ Cell Phone #: ________________

Do you prefer to receive calls at: ☐ Home ☐Work ☐Cell ☐ No Preference

☐Married ☐Widowed ☐ Single ☐Minor ☐ Separated ☐ Divorced Social Security Number(opt.)________________

Patient Employer/School______________________ Work Phone ______________

Spouse or parent's name______________ Whom may we thank for referring you to us?______________

Person to contact in case of emergency________________________ Phone ________________

Check off any of the following symptoms you have experienced in the past 6 months:

☐ Low Back Pain
☐ Pain between Shoulder Blades
☐ Neck Pain
☐ Tension/Headaches
☐ Fibromyalgia

☐ Tension Across Top of Shoulders
☐ Numbness/Tingling in Arms/Hands
☐ Numbness/Tingling in Legs/Feet
☐ Pain in the legs
☐ Pain in the feet

☐ Tired/Fatigued
☐ Difficulty Sleeping
☐ Allergies
☐ Digestive Problems
☐ Carpal Tunnel

OTHER (explain) ____

Which of the above is the worst? ____

How long have you had it? ____

How often does it occur? ____

What does it feel like? (describe) ________________________________

What have you done that has helped this problem? ________________________________

What activities would you like to do if this was not a problem? ________________________________

Does this cause you to be:
☐ Moody
☐ Irritable
☐ Interrupt sleep
☐ Restricted in your daily activities

Does this affect your work:
☐ Decision making
☐ Poor attitude
☐ Decreased productivity
☐ Exhausted at the end of the day
☐ Unable to work long hours

Does this affect your life:
☐ Lose patience with spouse/children
☐ Restricted household duties
☐ Hinders ability to exercise or sports
☐ Interferes with ability to do hobbies or other activities

What have you tried to help relieve/get rid of this problem and how much did it help? (Circle appropriately)

◆ Medications............Helped: Little Some Much
◆ Physical Therapy.......Helped: Little Some Much
◆ Chiropractic............Helped: Little Some Much
◆ Exercise........Helped: Little Some Much
◆ Nutrition...... Helped: Little Some Much
◆ Stretching......Helped: Little Some Much

I consent to receiving a health screening. I realize that I am not receiving a diagnosis, treatment or prognosis for any condition that I may be experiencing. I acknowledge that I am receiving a demonstration only and agree to hold harmless the therapist and/or clinic from any damage resulting from this demonstration.

Signature: ________________________________ **Date:** ____/____/____

NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE

NAME ______________________________ **DATE** __________

For any YES answer, please include details.

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment: ______________________________

2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment: ______________________________

3. Do your hands or arms fall asleep regularly? NO YES
   Comment: ______________________________

4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment: ______________________________

5. Do you suffer from a loss of handgrip strength? NO YES
   Comment: ______________________________

6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment: ______________________________

7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: ______________________________

8. Do our legs or feet fall asleep regularly? NO YES
   Comment: ______________________________

9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
   Comment: ______________________________

10. Do you suffer from cold hands or feet? NO YES
    Comment: ______________________________

11. Have you tried any medications such as anti-inflammatory? NO YES
    If yes, what kind of medication?
    ____

12. Have you tried any Physical Therapy or Chiropractic treatments before? NO YES
    If yes: When? For how long? What kind?
    ____

13. Have you had an MRI? NO YES
    If yes: When? Who ordered it? What was it ordered for?
    ____

14. Have you used any splint or braces or other prescribed treatment by an MD? NO YES
    If yes: When? What kind? Who ordered it?
    ____

15. If you have tried any treatment or medications, did this make your problem better? NO YES
    Comment: ______________________________

For any yes answer, rule in/out the diagnosis with these two tests:

A) NCV/EMG tests Upper Lower Indicated Not Indicated (circle one)

B) Vascular Test Indicated Not Indicated (circle one)

CONSENT TO CARE

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the foregoing.

______________________________ Patient's Signature

______________________________ Date

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: ______________________________

☐ There is a possibility that I a may be pregnant at this time.

☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time

☐ I request that x-ray films not be taken because: ______________________________

Date of last menstrual period: ______________________________

______________________________ Patient's Signature

______________________________ Date

Optimal Healthcare Physical Medicine

Financial Office Policies

1. All patients are on a cash basis until our staff can verify all insurance coverage(s).
2. Your insurance will be verified promptly and will be reviewed with you if applicable.
3. After coverage and deductible are verified, this office may accept assignment on most policies provided the insured/patient signs an appropriate statement of benefits and/or a lien authorizing payment to be sent to the doctor.
4. Waiting for the insurance payment is a courtesy and it may be withdrawn under certain circumstances.
5. As a patient, it is your responsibility to take care of the co-payment (usually a percent or fixed dollar amount) and any non-covered services on a monthly basis. This office may make payment arrangements on an individual basis. Any such plan or arrangements will be discussed during your report of findings.
6. This office does not warrant or guarantee that your insurance company will pay, nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between the insurance carrier and the patient/insured.
7. Any service not covered or coverage reductions by your insurance carrier will be the patient's responsibility.
8. This office will submit an insurance claim for you. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly with your insurance adjuster or agent. Any denied or disputed claims will be treated as uncovered.
9. If your account should go to collections for any reason, it will be the patient's responsibility for any court costs, attorney's fees, and or collection costs incurred in collecting the account balance.
10. I authorize the release of any medical or other records or information from my health record. I authorize release of records or information necessary to process any claims.
11. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due. This means refunds are made only after your balance is completed and cleared with this office.
12. If you receive correspondence of checks from your insurance company, you agree to bring these into our department so that we may determine if any action needs to be taken or if the check is on assignment to this office.
13. If you change insurance companies or employers, you agree to provide this office with the current information immediately.
14. If this office gives you any professional or accounting discount for treatment and you decide to drop out of care then our standard fees will apply.
15. This office accepts MasterCard, Visa, American Express, Discover Card, personal checks and cash.
16. If you have any questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the doctor.
17. If you stop care and have a financial agreement signed with our office, you will be responsible for any/all charges that you have incurred at our office.

Thank you for your cooperation in this matter.

I have read and fully understand the financial office policy and agree to abide by these terms.

________________________________   _____/_____/_____

Patient Signature or Responsible Party   Date

Non-Assignment of Insurance Benefits Policy

I have been informed that my insurance company will not assign benefits over to this office. This means that any amount due to the doctor's office would be mailed to me, the patient, and not to this office. Since my insurance company will not assign benefits directly to the office, I am opting to follow the below 'Non- Assignment of Benefits' policy.

Our office will treat you and you will be responsible to pay your deductible, co-payments or coinsurance that is due for each of your allowed visits by the insurance company. To do this, our office will need a credit card on file. As the insurance disburses funds to you, the patient, you are required to bring the payments to this office within seven (7) days. As you receive payments, or an Explanation of Benefits (EOB), our office also receives a copy of what you received, minus any payments. If we have not received the payment from you, the patient, within seven (7) days, our office will charge that amount that you received from the insurance company on the credit card on file.

NOTE: We will only charge the credit card if payment is not brought in within seven (7) days.
If unusual circumstances should arise where you can't bring the payment in, please call the office to let us know so the credit card won't be charged. (Ex. You're out of town, emergency, etc.)
If the insurance company denies your claim, you will be responsible for services rendered.
I have read the above policy and my signature below indicates that I understand and agree to follow this policy.

____
Patient's Printed Name

_______/________/_______
Date

____
Patient's Signature

Instructions:

1. Have the "Insured" person of the policy sign the back of the check
2. Bring the check and EOB (explanation of benefits) to our office within 7 days.
   DO NOT DETACH THE CHECK FROM THE EOB.
3. Give the EOB/Check to the front desk when you arrive to our office. We will make a copy for your records.

Optimal Healthcare Physical Medicine

PATIENT MISSED APPOINTMENT POLICY

DEFINITIONS:

POLICY- a way of managing affairs so as to achieve some purpose.
APPOINTMENT- a meeting with someone at a certain time and place.
MISSED- fail to keep, do, or be present at.

It is our wish that each and every one of our patients receive the very best care and service possible.

Your Treatment Program consists of a specific series of treatment given over a pre-planned time span. If you do not follow this plan, then you will not receive the desired results. If we did not insist that you meet all your appointments, we would be doing you a disservice and it would be indicative that we did not care. We do not want to do you a disservice and we do care about you and the success of your program here. Therefore, we have a few simple rules that we insist you follow:

1. Meet all your appointments. Arrange the activities in your life so that this can occur.
2. If you become ill, we still want you to come in, because **Treatments** will help you recover.
3. If you are unable to make it in due to an emergency, please call us and let us know so we can reschedule your appointment.
4. With the exceptions of unexpected emergencies, we require that you notify us at least 24 hours in advance as to any appointment changes.
5. All cancelled or missed appointments must be rescheduled and made up within one week.
6. There is a $5.00 service charge for no call/no show appointments.
7. There is also a $20.00 charge for missing an appointment with the medical doctor.

I have read, understand, and agree to follow the above policy.

Patient's Name: ______________________________

Signature: ______________________________

Staff Witness: ______________________________

LECHMAIER FAMILY CHIROPRACTIC CENTER

PAYMENT POLICIES

1. All first visit charges are payable when services are rendered.

2. At the completion of your first office visit you will be advised as to a time you may return for your second consultation when the doctor will inform you as to your examination results and whether or not your case has been accepted. You will then be advised concerning treatment options, financial arrangements, and insurance coverage as appropriate.

3. Method of payment you plan to use to take care of today's charges? ☐ Cash ☐ Check ☐ Visa/MasterCard

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Lechmaier Family Chiropractic Center will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Lechmaier Family Chiropractic Center will be credited to my account upon receipt. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account. I authorize Lechmaier Family Chiropractic Center to obtain a credit report if deemed necessary.

Patient Name ______________________ Patient's Signature ______________________ Date ________

DIRECT PAYMENT AUTHORIZATION

I hereby instruct and direct payment to be made payable to and mailed directly to:

LECHMAIER FAMILY CHIROPRACTIC CENTER
852-35 SAXON BLVD.
ORANGE CITY, FLORIDA 32763
OFFICE: 386-775-3600 FAX: 386-775-3602

In consideration of the services rendered I authorize and direct the payment to the above named of any sum I now or hereafter owe out of the proceeds of any settlement of my case, and/or by any insurance company obligated to reimburse me for the charges for these services. The payment will not exceed my indebtedness to the above mentioned.

A photocopy of this authorization shall be considered as effective and valid as the original. I authorize the use of this form for all insurance claims from Lechmaier Family Chiropractic Center.

Patient Name ______________________ Patient's Signature ______________________ Date ________

X-RAY / MEDICAL RECORDS RELEASE

I authorize the release of any medical information necessary to physicians, employers and/or insurance companies which would expedite the process of my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

I authorize the taking of photographs and x-rays to be used for treatment purposes.

I authorize the performance of other diagnostic and therapeutic procedures for treatment purposes.

I have requested the release of records of (patient's name)______________________ which are a part of the records at (facility)______________________

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them, all insurance information, copies of records and reports, including copies of x-rays, and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future.

Patient Name ______________________ Patient's Signature ______________________ Date ________

Guardian Name ______________________ Guardian's Signature ______________________ Date ________

SEMI-OPEN ROOM ADJUSTING CONSENT FORM

I hereby give consent to have chiropractic adjustments performed in a semi-open room setting. I acknowledge that closed rooms are available to me at any given time, but my result in longer wait times. I understand that a semi-open room setting does not ensure complete privacy and will inform the staff if I need to discuss any confidential information in private.

Patient Name____________________ Patient's Signature____________________ Date__________

TERMS OF ACCEPTANCE AND CONSENT FOR CARE

THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE

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 goal.

Chiropractic has only one goal. It is important for each patient to understand this goal and the method that will be used to attain it. This will prevent confusion or disappointment.

"Vertebral Subluxations" are mechanical interferences, by the spinal bones, to the normal flow of mental impulses traveling over the nerve pathways. The goal of chiropractic is to locate, analyze and correct these vertebral subluxations.

The method of correction is by specific adjustments to the spine. These adjustments are intended to reduce vertebral subluxations, thereby allowing the innate healing abilities of the body to work at maximum efficiency.

With a proper nerve supply restored through chiropractic adjustments, the body can begin the process of repair leading to health. In some patients this happens quickly; in others, more slowly. In some patients the repair and maintenance is complete; in others, only partial.

We do not offer to diagnose or treat any disease or condition other the vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of the health care provider who specialized in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY GOAL IS TO ALLOW THE BODY TO DO ITS JOB. Our only method is the spinal adjustment of vertebral subluxations.

I, ____________________ have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on that basis ____________________ __________
(Signature) (Date)

Complete if Patient is a minor child.

____
(Print Child's Name)

I, ____________________ being the parent or legal guardian of the aforementioned child have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

____________________ __________
(Signature) (Date)

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED INFORMATION

PATIENT NAME: ____________________________ DATE OF BIRTH:___________________

ADDRESS:__________________________________ CITY AND ZIP:____________________

TYPE OF PRIVATE HEALTH INFORMATION TO BE RESTRICTED OR LIMITED
(PLEASE CHECK ALL THAT APPLY)

- o HOME ADDRESS
- o HOME PHONE NUMBER
- o WORK PLACE
- o VISIT NOTES
- o PATIENT HISTORY
- o OFFICE ADDRESS
- o SPOUSE'S NAME
- o SPOUSE'S OFFICE NUMBER
- o OTHER

OUR OFFICE PROMISES NOT TO RELEASE ANY INFORMATION ABOUT YOU UNLESS YOU HAVE SPECIFICALLY SPECIFIED IT BELOW TO HAVE PERSONALLY GIVEN US WRITTEN PERMISION TO DO SO.

PLEASE LIST ANY PERSON BELOW THAT WE MAY RELEASE YOUR PERSONAL INFORMATION TO.

____

____

____

PATIENT SIGNATURE OR LEGAL GUARDIAN________________________________

DATE_____________

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name ______________________ Date ____________

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain 0 1 (2) 3 4 (5) 6 7 (8) 9 10 **worst possible pain**

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1 – What is your pain RIGHT NOW?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

2 – What is your TYPICAL or AVERAGE pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

OTHER COMMENTS:

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____
Examiner

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