Confidential Patient Information

Please complete this questionnaire and the following forms. Your answers will help us determine if our care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. This information will also help us to get to know you as a person and will help us determine how we can best meet your needs.

Patients Name _____ Age _____ Date of birth _____

Address_____City_____State_____Zip_____

Home phone _____Cell Phone_____Work Phone_____

E-Mail Address _____ Marital Status: M S D W

Employer_____Address _____ City_____

State _____ Zip_____ Occupation _____

Spouse's Name _____ Date of birth _____

Number of Children _____ How did you learn about our office?_____

Personal Medical history (if any of the following are relevant to your medical history, please check box)

☐Cancer	☐Muscular Dystrophy	☐Rheumatic Fever	☐Digestive Disorders	☐Polio
☐Multiple Sclerosis	☐Scarlet Fever	☐Sinus Trouble	☐Tuberculosis	☐Convulsions
☐Nervousness	☐Backaches	☐Arthritis	☐Epilepsy	☐Asthma
☐Numbness	☐Heart Trouble	☐Concussion	☐Dizziness	☐Diabetes
☐High Blood Pressure	☐Hepatitis	☐German Measles	☐Venereal Disease	

Describe any operations/accidents you've had and the dates: _____

Have you been treated for any health condition in the past year? ☐ Yes ☐ No. If yes, please explain

_____

List medications and vitamins you are currently taking _____

Are you pregnant? ☐ Yes ☐ No ☐ N/A

Do you have Medical Insurance? ☐ Yes ☐ No. Company_____ ID#_____ Group #_____

I hereby authorize Worthington Family Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary, and I also authorize the release of any information acquired during the course of my examination or treatment. I certify that the above information is true and correct.

SIGNATURE AUTHORIZING CARE _____ DATE _____

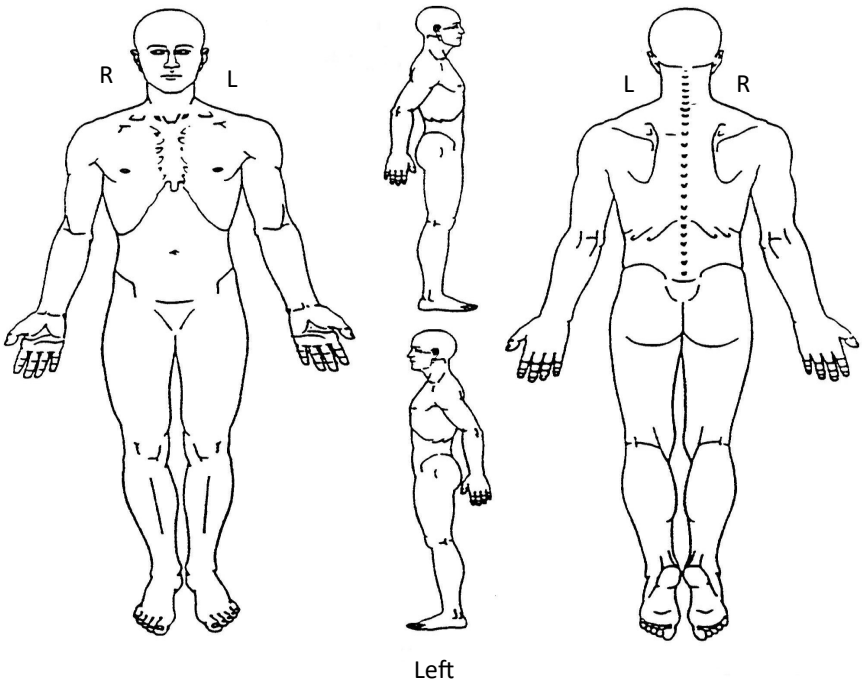
57 E. Wilson Bridge Road Suite 200 * Worthington, Ohio 43085 * Phone: (614) 785-9999 * Fax: (614) 785-9995
Website: www.drdaniellerice.com * Email: drdaniellerice@yahoo.com

CASE HISTORY

Name _____ Date of Birth_____ Todays Date _____

Reason for seeking chiropractic care: (Please list **ALL** complaints)_____

_____



Please circle degree of pain

O=No pain 10=Very severe pain

0 1 2 3 4 5 6 7 8 9 10

What is your frequency of pain?

(% of the week you experience the pain)

0 10 20 30 40 50 60 70 80 90 100

Using the symbols below, mark on the pictures where you feel pain.

Numbness: **====**

Dull Ache: **OOOO**

Burning: **XXXXX**

Sharp/Stabbing **///////**

Pins and Needles **++++**

Numbness - - - - -

Tingling **^^^^^**

Throbbing **SSSSS**

When did your symptoms begin? (onset date) _____ Have you experienced this before? Yes/No (please circle)

How did your symptoms start? _____

Do your symptoms radiate? Yes/No/Sometimes (**please circle**) If yes, where do they radiate to? _____

Are your symptoms worse in the morning, afternoon or night? (**please circle**) explain _____

Do your symptoms increase during the day, same all day or decrease during the day? (**please circle**)

Are your symptoms improving/ getting worse/ or staying the same since it began? (**please circle**)

Circle **ANY** and **ALL** activities that aggravate your condition/pain? (**please circle**)

Bending	Lifting	Lying	Walking
Standing	Sitting	Movement	Twisting
Sleeping	Other _____		

Please explain in detail_____

_____

Worthington Family Chiropractic Dr. Danielle Rice 57 E. Wilson Bridge Rd. Ste 200 Worthington, OH 43085 614-785-9999 voice 614-785-9995 fax

Worthington Family Chiropractic

CASE HISTORY (Page 2)

List ALL activities that **aggravate** your condition/pain?_____

List ALL activities that **lesson** your condition/pain? _____

Do you sleep on your back, side or stomach? (**Please circle ALL that apply)**

What treatments have you tried prior to our office (ex. Physical Therapy, Massage therapy, Acupuncture, Ice, Heat, Medications, etc…) and were your result Good or Poor? **Please explain** _____

_____

Have you had an MRI, CAT scan, X-ray or any other diagnostic tests for this problem? If yes, then when?_____

_____

What would you like to do that you can not at this current time due to your pain? (ex. Vacuum/golf/clime stairs/walk/exercise/ work/pickup your grandkids, etc...)

_____

_____

Any additional information you would like the Doctor to know? _____

_____

_____

_____

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ Todays Date _____

FINANCIAL AGREEMENT

NPI: 1427278506 TIN: 20-1254026

We are thrilled to welcome you to Worthington Family Chiropractic.

Listed below you will find an explanation of our services and fees.

1st Visit: Consultation

Examination (99203)

Posture Scan and evaluation

Spinal X-rays (72050)

2nd Visit: Report of Findings

Spinal Adjustment (98940-98941)

Post Spinal x-ray (72040)

$365 Total for all services described above

Follow-up care

Patients will be evaluated at each visit to determine if a subluxation is present. Adjustments will be administered as indicated. Prices provided reflect our Good Faith Estimate. Services vary based on the individual treatment plan listed in the patients report of findings packet provided prior to first adjustment.

Adjustments: 98940-98941 **($60)**
Active Medicare Adj.: 98940-AT **($28.23)** 98941-AT **($40.76)**
Medicare Maintenance Adjustment: 98940-GA **($45)**
Office visit/no adjustment: **($30)**
Progress Exam/Re-evaluation: 99213 **($50)**
Additional X-rays: **($50/x-ray)**

Other Services: Additional services offered at Worthington Family Chiropractic include, but not limited to nutritional supplements, Ice packs, Biofreeze, and kinesiotape. These services have fees associated with them and are not included in the adjustment or evaluation fees

Insurance/Medicare: Worthington Family Chiropractic is an out of network provider with all insurance companies and Medicare. Payment is due at the time of service. We will be happy to provide you with all the necessary forms and/or documentation for reimbursement through your provider upon request. Medicare claims will be submitted directly to Medicare while under Active Medicare treatment according to Medicare guidelines. Reimbursement checks for Active Medicare treatment will be sent directly to the patients from Medicare. Medicare Maintenance is no longer paid for by Medicare and will be the responsibility of the patient.

I have read and understand the above mentioned information. Any unused fees paid to Worthington Family Chiropractic will be refunded to the patient within 14 days of request.

Name:_____ Date_____

Worthington Family Chiropractic Dr. Danielle Rice 57 E. Wilson Bridge Rd. Ste 200 Worthington, OH 43085 614-785-9999 voice or 614-785-9995 fax

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

_____

Patient

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the Acknowledgment
- ☐ An emergency situation prevented us from obtaining Acknowledgment
- ☐ Other (Please Specify) _____

_____

_____

Staff signature Date

Dr. Danielle Rice
57 E. Wilson Bridge Rd. Ste 200 Worthington, OH 43085
614-785-9999