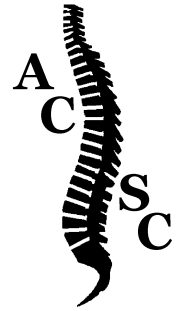


Advanced Chiropractic & Spine Center of Souderton

Dr. Keith M. Miller

655 East Broad Street
(215) 703-9999 Phone
DrMiller@Drspine.net

Souderton, PA 18964
(215) 703-9897 Fax
www.DrSpine.net



NAME: _____ DATE: ____/____/____

STREET ADDRESS: _____ APT/SUITE#: _____

CITY: _____ STATE: _____ ZIP: _____

MOBILE#: (____) _____ WORK#: (____) _____ ext. _____

HOME# : (____) _____ Email: _____

BIRTHDATE: ____/____/____ AGE: _____ ACTIVE/RETIRED MILITARY: YES / NO

MARITAL STATUS: Single / Married / Separated / Divorced / Widowed

EMPLOYER: _____ JOB TITLE: _____

EMERGENCY CONTACT: _____ RELATION TO YOU: _____

PHONE#: (____) _____

We would like to thank the patient who referred you to our office; whom should we thank for their kind referral? If you were not referred by another patient, how did you hear about our office?

Welcome to Advanced Chiropractic & Spine Center

It is our goal in this office to give you, our new patient, the best possible overall care that we are able to provide. In order to achieve this goal we must first spend some time collecting pertinent information about your problem or problems. Please be as open, honest and specific as you can, as it allows us to give you the most accurate and complete treatment for your condition. All information provided is kept strictly confidential, except for insurance or documentation purposes. Should you require assistance at any time filling this out, do not hesitate to ask a member of our health and wellness team for help.

Thank you for choosing our office, and please tell a friend! ☺

What is THE MAJOR complaint(s) that brought you into our office today?

Is your injury due to a work related accident or auto accident?

Automobile accident ____ Date of accident ____/____/____ Accident report filed Y N

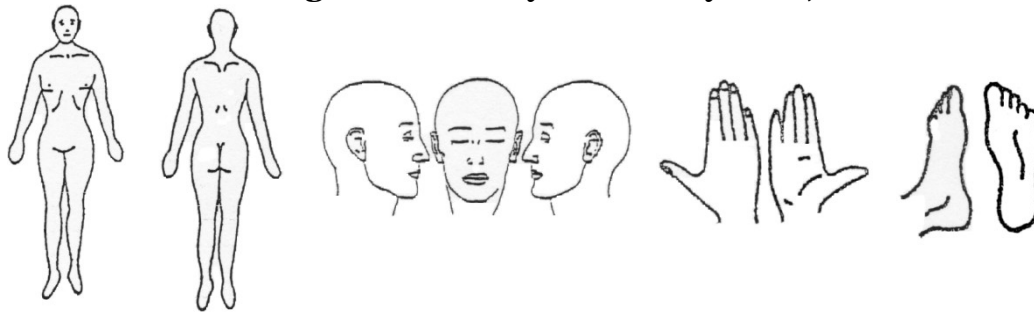
Injury on the job ____ Date of accident ____/____/____ Accident report filed Y N

Have you ever seen a Chiropractor? No / Yes (Who) _____

My Current Family Physician is _____ **Phone#** _____

I am / may be Pregnant: Yes / No **If Yes, are you under a doctor's care:** Yes / No

Please mark the diagrams where you feel any Pain, Numbness & Tingling:



Which of the following apply to you presently: (Please X all that apply)

	PAIN		NUMBNESS		TINGLING	
	Left	Right	Left	Right	Left	Right
Head						
Neck						
Upper Back						
Mid back						
Lower Back						
Shoulder						
Arm						
Forearm						
Hand/Fingers						
Buttock						
Hip						
Thigh						
Leg						
Foot						

My pain and symptoms may be aggravated by the following:

Coughing ____ Sneezing ____ Straining of Stool ____ Neck Movement ____

Reaching ____ Lifting ____ Bending at Waist ____ Sitting ____ Standing ____ Walking ____

Weather Changes ____ Other ____

Since my symptoms began, I have noticed a change in my:

Bowel Functions ____ Bladder Function ____ Ability to Maintain an Erection ____

The following questions are to help us assess your present total health. The questions may or may not **seem** to have anything to do with your illness, condition, or accident... however injuries to your neck, head, and back can often directly impact your present health. Place an **X** if you are now (**or in the past six months**) suffering from any of the following:

General

Chills ____ Fatigue ____ Weight Changes ____ Weakness ____ Night Sweats ____ Fever ____

Skin

Redness ____ Rash ____ Itching ____ Eczema ____ Hair changes ____ Nail Changes ____
Color Changes ____ Abnormal Growths / Moles ____ Other _____

Neurologic

Fainting ____ Headaches ____ Migraines ____ Convulsions ____ Dizziness ____ Seizures ____

Eyes

Vision Problems R / L Pain R / L Discharge R / L Auras or Halos R / L

Ears

Problem Hearing R / L Ringing R / L Pain R / L Discharge R / L

Nose

Allergies ____ Sinus Infection ____ Pain ____ Bleeding ____ Unable to Smell ____

Mouth / Throat

Blisters/Sores ____ Bleeding ____ Unable to Taste ____ Strange Tastes ____ Discharge ____

Heart / Lungs

Cough ____ Wheezing ____ Difficulty Breathing ____ Murmur ____ Chest Pain ____
Palpitations ____ Too Fast / Slow Heart Rate ____ Swollen Limbs ____ Blue Limbs ____

Breasts

Lump(s) in Breast(s) ____ Pain/Soreness ____ Redness ____ Redness\Itching ____ Dimpling ____
Discharge ____

Stomach / Intestines / Digestion

Decreased Appetite ____ Increased Appetite ____ Abdominal Pains ____ Reflux ____
Vomiting ____ Diarrhea ____ Gas & Bloating ____

Reproductive Function / Urination / Bowel Function

Unable to Hold Urine ____ Frequent Urination ____ Painful / Burning Urination ____
Irregular Menstruation ____ Painful Menstruation ____ Abnormal Vaginal Bleeding ____
Impotence ____ Sterility ____ Constipation ____ Painful Stool ____ Bloody Stool ____

Glandular

Hot / Cold Intolerance ____ Goiter ____ Shakes / Tremors ____ Sugar in Urine ____

Mental

Depression ____ Anxiety ____ Mood Swings ____ Phobias ____ Memory Loss ____

Which of the following illnesses have you ever had?

No Illnesses / Conditions Allergies____ Arthritis____ Asthma____ Sinus Trouble____
Hay Fever____ Tuberculosis____ Diabetes____ Epilepsy____ Thyroid Problems____
High Blood Pressure____ Low Blood Pressure____ Heart Problems____ Ulcer____
Cancer____ Polio____ Rheumatic Fever____ Serious Injury____ Bone Fracture(s)____
Dislocated Joints____ Spinal Disc Disease____ Multiple Sclerosis____ Scoliosis____
Mental/Emotional Difficulty____ Prostate Problems____ Kidney Problems____
Bleeding Disorder____ AIDS\HIV+____ Sexually Transmitted Disease____
Other:_____

If any member of your immediate family has an illness/problem listed above, please enter relation/condition:_____

The following Social History will help in our treatment of your problem(s):

I smoke: Never ____ 1/2 Pack a day or Less ____ 1/2 to 1 Pack a day ____ A Pack or More ____

I drink alcohol: Never ____ With some Meals ____ Socially ____ Often ____ Daily ____

I usually exercise: Aerobic____ Weight Training____ Running____ Other____
1-2x per week____ 3-4x per week____ Daily____

My normal hobbies, sports, activities & family responsibilities include:_____

My current condition(s) / problem(s) keep me from doing the following:_____

Please Read the following agreement and sign date below:

I understand and agree that both health and accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that Advanced Chiropractic & Spine Center, Inc. and its affiliates will prepare any necessary reports and forms to assist me in my collections from the insurance company, and that any amount authorized to be paid directly to this office will be credited to my account and not paid to me directly. Additionally, any payments made to me directly by an insurance agent / carrier for the purpose of covering billed services of this office will be signed over / remitted within 14 business days if the billed amount was not already prepaid. If your injuries are a result of an automobile accident(s) or workman's compensation claim, and a lawyer(s) was\were retained, I authorize that all proceeds of claims or suits be paid directly to the care provider(s) immediately upon receipt of settlement before any other payout related to this claim. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and/or treatment, any fees for professional services rendered me will become immediately due and payable.

Patient's Signature or Legal Guardian_____

Date ____/____/____

Electronic Health Records Intake Form

In compliance with mandatory 2018 requirements for the government EHR incentive program

First Name: _____ Last Name: _____

Email address: _____@_____

Preferred method of communication (Circle one): Email / Phone / Mail

Gender (Circle one): Male/Female/Decline to Specify Language: _____

Smoking Status(Circle one): Every Day Smoker/ Light Smoker / Ex-Smoker (Quit) / Never Smoked

*CMS & the government EHR incentive programs requires health providers to report **both** race and ethnicity*

Race (Circle one): White (Caucasian) / American Indian or Alaska Native / Asian / African American
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently **taking** any medications? (Please include regularly used over the counter medications)

** You may use the back of this form if you need to, or attach a written list of medications if that is easier **

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication **allergies**?

Medication Name	Reaction	Onset Date	Additional Comments

Do you have a pacemaker or any heart condition? No/ Yes (Specify) _____

Patient Signature: _____ Date: _____

Height: _____ Weight: _____ Blood Pressure: _____ / _____

Advanced Chiropractic & Spine Center

Office Policies Summary – 2022

GENERAL POLICIES

- Payment is due at time of service unless arrangements have been made prior with the office billing coordinator.
- Office staff will always try their best to collect from your insurance company; however, payment for services is **always the responsibility of the patient**
- Please arrive at your scheduled appointment time. If you are going to be **more than 10 minutes early or late** please contact the office to ensure there is room in our schedule at that time. Early arrival *does not guarantee* we can see you sooner.
- If you are **more than 10 minutes late**, we reserve the ability to appropriately adjust your therapies so we can accommodate you between other scheduled patients.

INSURANCE & PAYMENT POLICIES

- I understand that the patient, not the office, is responsible for getting a referral. Office staff will do their best to assist in this process.
- If my insurance requires a referral / pre-authorization and it cannot be obtained, I understand that **I will be charged directly out of pocket** at the current self-pay rate for these services.
- If my insurance has an un-met Deductible in 2022, that must be met before benefits are paid to the office. I understand that ACSC will bill me a minimum of \$50 towards the patient responsibility / deductible at the time of each service date pending the Insurance Processing and Explanation of Benefits. In the *rare event* of an overpayment, the office will contact within 45 days to notice of any over payments.
- I am responsible for immediately informing staff of any changes to my insurance plan and am ultimately responsible for any services in the office that remain unpaid due to lapse in coverage.

Patient Fees: Minimum New Patient Exam \$60, Minimum Re-Exam \$40 (out of office >6 months) , Minimum Chiropractic Treatment \$50, Soft Tissue Massage Therapy starting at \$35

SOFT TISSUE & MASSAGE THERAPIST APPOINTMENTS

- If I cancel my soft tissue therapy appointment without giving >24 hour notice and/or no call no show for the appointment, **I will be charged** a missed / canceled appointment fee based on the length of appointment.
- If I am late to my appointment, **I surrender that time** and understand that the therapist cannot go into another patients scheduled time.
- I am responsible for the full cost of the scheduled appointment regardless of check-in time.

PRINTED Name (or guardian)

Signature

Date

WITNESS Name (ACSC staff)

Signature

Date

HIPAA Privacy Disclosure & Informed Consent to Chiropractic Treatment

PRIVACY NOTICE: I acknowledge that I have the right to request either a long full version of the practices privacy policy or a summary short form at any time. I am aware that the office has a privacy policy that complies with the 2018 federal HIPAA guidelines, and by my signature accept and acknowledge my rights and conditions under this posted and available policy upon request. Should you wish to have a copy printed for you please request it at anytime. Your signature below accepts our HIPAA policies.

The nature of chiropractic treatment: The doctor will use his/her hands or use a mechanical device / table in order to move your joints with chiropractic “adjustment” or “manipulation”. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint(s). Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, x-ray, digital imaging, therapeutic ultrasound, decompression, axial traction, extension compression traction, rehabilitation, exercising and stretching, inter-segmental traction, flexion-distraction traction, therapy ball, massage therapy, soft tissue muscle therapy, various topical pain relief gels creams and/or lotions, etc may also be used in conjunction with your treatment.

Possible Risks: I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. As with any health care procedure, complications are possible following a chiropractic manipulation /ancillary therapies. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications. Complications, while extremely rare, could include but are not limited to: fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, and injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck in *extremely rare* instances of manipulation.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as “rare”, far less often then complications seen from the taking an NSAID or Aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated according to the ACA in 2014 as one in 5,850,000 million treatments, and can be even further reduced by proper screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”, but can occur at any time.

Other treatment options & referrals which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases. Medications such as NSAIDS/Aspirin have been shown to cause heart damage & death at a risk rate of 153 in 1,000,000 (*Am J Gastroenterology* 2005, Aug;100(8):1685-93)
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics / narcotics. Risks of these drugs include a multitude of undesirable side effects and patient dependence / addiction in a significant number of cases and even death.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases. Many patients treated in hospitals leave with conditions new / worse than their original complaint.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases. Surgery can result in increased symptoms, permanent loss of function or death.

Risks of remaining untreated: Delay of proper chiropractic treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment can complicate the condition and make future care more difficult. Patients **who do not follow** their recommended chiropractic treatment plan may revert to their original symptoms, or even become worse from failing to finish treatment.

Informed consent:

I have read the explanation above of chiropractic treatment & modalities \ referral \ options. I know have the opportunity to have any questions answered to my satisfaction at any time. I have fully evaluated the risks and benefits of undergoing treatment. I freely decide to undergo the recommended treatment and/or procedures and hereby give my full consent to treatment and release the office and staff from future liability which may result from care. I accept these risks for the potential benefits of treatment in this office. I accept these risks fully, without coercion, and give my informed consent.

PRINTED Name (or guardian)

Signature

Date

WITNESS Name (ACSC Staff)

Signature

Date