

Bergkamp-Engle Chiropractic – Confidential Patient Data

Name: _____ Today's Date _____

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Work _____ ext _____ Cell _____

Which contact phone number do you want messages left on? Home Work Cell

Email Address: _____

Social Security # _____ Date of Birth _____ Age _____

Occupation _____ Employer _____

Marital Status: M S W D Name of Spouse _____ Spouse DOB _____

Referred to our Office by _____ Feist SBC User Friendly

Payment by: cash check credit card insurance auto accident work comp

(if we are filing insurance for you, please let us copy your insurance card)

Current Health Status

What complaints bring you in our office? _____

When did you notice this? _____ What happened? _____

What makes it worse? _____ What makes it better? _____

Circle the quality of the pain? Achy Burning Numbness Pulling Stabbing Throbbing Other _____

Does the pain move anywhere? _____ where? _____

On a scale of 1-10 (0 = no pain and 10 = worst possible pain) What is your pain right now? _____

What is your typical pain? _____ What is your pain level at its best? _____ and at its worst? _____

Is your pain? Always there Sometimes Assisted with Painful Positions Associated with Painful Activities

What part of your lifestyle does your complaint interfere with? _____

Have you been to another doctor for this problem? _____ who? _____

Medical/Family History

What condition(s) have you been previously diagnosed with? _____

Family History: Heart Disease Diabetes Cancer Arthritis Other? _____

What previous surgeries have you had and when? _____

Have you ever been in the hospital, for what? _____

Have you had any auto accidents and when? _____

Have you had any job related accidents and when? _____

Do you drink alcohol? _____ Do you smoke? _____ Have you broken any bones? _____

Medications for? _____ Allergies or Adverse reactions? _____

Are you: exercising? _____ dieting? _____ taking supplements? _____ Pregnant? _____ Due Date: _____

Is there anything else I should know about you? _____

The statements made above are accurate to the best of my knowledge and I agree to allow this office to examine me for further evaluation and treatment.

Patient Signature _____ Date _____

Information on this sheet is subject to interpretation by the user.

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Bergkamp-Engle Chiropractic Questionnaire

Patient name: _____ PT # _____ Date: _____

When your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences that describe you today.

- I stay at home most of the time because of my back.
- I change positions frequently to try to get my back comfortable.
- I walk more slowly than usual because of my back.
- Because of my back, I am not doing any of the jobs I usually do around the house.
- Because of my back, I use handrails to get upstairs.
- Because of my back, I have to hold on to something to get out of an easy chair.
- Because of my back, I lie down to rest more often.
- Because of my back, I try to get other people to do things for me.
- I get dressed more slowly than usual because of my back.
- I only stand up for short periods of time because of my back.
- Because of my back, I try not to bend down or kneel.
- I find it difficult to get out of a chair because of my back.
- My back is painful almost all of the time.
- My appetite is not very good because of my back.
- I have trouble putting on my sock/stocking because of the pain in my back.
- I can only walk short distances because of my back.
- I sleep less well due to my back pain
- Because of my back pain, I am more irritable.
- I sit down for most of the day because of the pain in my back.
- I avoid heavy jobs around the house because of my back.
- Because of my back, I am more irritable and bad tempered with people than usual.
- Because of my back, I go upstairs more slowly than usual.
- I stay in bed most of the time because of my back.

Patient signature

Date

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Is chiropractic treatment safe?

Chiropractic is widely recognized as one of the safest drug-free, non-invasive therapies available for the treatment of neuromusculoskeletal complaints. Although chiropractic has an excellent safety record, no health treatment is completely free of potential adverse effects.

The risks associated with chiropractic, however, are very small. Many patients feel immediate relief following chiropractic treatment, but some may experience mild soreness or aching, just as they do after some forms of exercise. Current literature shows that minor discomfort or soreness following spinal manipulation typically fades within 24 hours.

Neck pain and some types of headaches are treated through precise cervical manipulation. Cervical manipulation, often called a neck adjustment, works to improve joint mobility in the neck, restoring range of motion and reducing muscle spasm, which helps relieve pressure and tension.

Neck manipulation is a remarkably safe procedure. While some reports have associated upper high-velocity neck manipulation with a certain kind of stroke, or vertebral artery dissection, there is not yet a clear understanding of the connection. The occurrence appears to be very rare—1 in 5.85 million manipulations—based on the clinical reports and scientific studies to date. If you are visiting your doctor of chiropractic with upper-neck pain or headache, be very specific about your symptoms. This will help your doctor of chiropractic offer the safest and most effective treatment, even if it involves referral to another health care provider.

It is important for patients to understand the risks associated with some of the most common treatments for musculoskeletal pain -- prescription and over-the-counter nonsteroidal anti-inflammatory drugs (NSAIDS) -- as these treatments may carry risks significantly greater than those of chiropractic manipulation. According to a study from the American Journal of Gastroenterology, approximately one-third of all hospitalizations and deaths related to gastrointestinal bleeding can be attributed to the use of aspirin or NSAID painkillers like ibuprofen.

Why is there a popping sound when a joint is adjusted?

Adjustment of a joint may result in release of a gas bubble between the joints that makes a popping sound – it’s exactly the same as when you “crack” your knuckles. The noise is caused by the change of pressure within the joint that results in gas bubbles being released. There is no pain involved.

The benefits and risks have been explained to you. You will be given the opportunity to ask questions. You are consenting to begin care.

HIPAA Notice of Privacy Practices - Acknowledgement and Consent Form

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for: treatment, payment, and health care operations. I understand your HIPAA Notice of Privacy Practices contains a more complete description of the uses and disclosures of my health information.

Patient Signature

Date

CONFIDENTIAL

BERGKAMP-ENGLE CHIROPRACTIC

Financial Agreement

Cash Patients

Payments are due on the date of services. We are happy to accept cash, check, MasterCard, Visa, or Discover. If I have any questions regarding the fees you can address them with the office staff. Special arrangements can be made if discussed in advance.

Insurance Patients

I, the undersigned certify that I have insurance coverage and assign directly to Dr. Bergkamp-Engle all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature below on all insurance submissions.

Medicare

Medicare will only pay for services that it determines to be 'reasonable and necessary' under section 1862(a)(1) of the Medicare law. The only service covered by Medicare is manual manipulation of the spine. Medicare does not cover x-rays or examinations or any therapy. Under some circumstances and with some Medicare carriers, these manipulations are limited according to your diagnosis. If Medicare denies payment for any services, I agree to be personally responsible for payment.

Auto Accidents

Please notify your auto insurance agent of your visit to our office immediately. If an attorney is handling your case, notify us immediately. Our office will supply your agent or attorney with all information needed to render payment of services.

Workers Comp

If you are injured on the job under Kansas law you are entitled to seek care from the doctor of your choice. You must obtain authorization from your employer. We must have the name and address of the insurance carrier to process the claim. If you do not provide this information, payment for services will be your responsibility.

All Patients

I understand that I am ultimately responsible for *timely payment* in full at this office. I understand that health and accident insurance policies are an arrangement between my insurance company and myself - not between my insurance company and this office. I authorize direct payment of medical benefits to Bergkamp-Engle Chiropractic and release of medical information necessary to process my insurance claims.

In the event the total balance due is more than you are able to pay, we will make reasonable payment arrangements. Please contact our billing office to make such arrangements. The diagnosis, prognosis, proposed care plan, and alternative care options will be explained to you. You will be given the opportunity to ask questions. You are consenting to begin care.

Signed _____ Date _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Health Information Technology for Economic and Clinical Health Act
HITECH Acknowledgement and Consent Form

Under the HITECH Act, we must comply with the restriction request in certain circumstances [if the disclosure is to a health plan for purposes of carrying out payment or health care operations (not treatment) and the PHI pertains solely to a health care item or service for which the health care provider has been paid in full].

Patients have the right to restrict us from providing your spouse with information, and other such restrictions on uses and disclosures. Other rights include a right to request an alternate means by which to communicate such as to a post office box and not to a patient's residence or place of employment. We will comply with alternative email communication requests as this is a reasonable method of communication.

Sometime after January 1, 2011 and before January 1, 2014 (date to be determined by the Health and Human Services) you will have the right to an accounting of all disclosures. You also have the right of access in electronic form of your EHR.

I authorize Bergkamp Chiropractic and its agents to disclose my information.

I authorize the following person to receive my information (must be 18 years old):

Relationship

I authorize the following information to be used or disclosed on my behalf:

- ALL my information** including health and financial information OR
- ONLY limited information** (mark all applicable blocks below):
 - Benefits & Coverage
 - Billing
 - Claims & Payments
 - Diagnosis & Procedure
 - Eligibility
 - Financial
 - Physician & Hospital
 - Pre-certification
 - Pre-authorization
 - Referral
 - Treatment
 - Medical Records
 - Behavioral Health
 - Other: _____

The following types of sensitive information will NOT be disclosed:
abortion, abuse (sexual/physical/mental), alcohol/substance abuse, genetic testing, HIV or AIDS, maternity, mental health, sexually transmitted or other communicable diseases or other such information.

The purpose of my authorization is to disclose the information at my request. If not previously revoked, this authorization will terminate upon an updated version of this form.

Patient Signature

Date

MINOR CHILD NAME(S):

Legal Representative Name:

Relationship:

Signature:

Date: