Bethesda Spine & Posture

Bethesda Spine & Posture
4733 Elm St. Ste 300, Bethesda, MD 20814
Tel: 301.656.2435 • Fax: 301.986.6960
www.bethesdaspineandposture.com
Bethesdaspineandposture@gmail.com

SECTION 1. ABOUT YOU

Today's Date: _____ / _____ / _____

Name: (Last) _____ (First) _____(Mid. Init.) _____

Birthday: _____ / _____ / _____ Age: _____ Gender: ☐ M ☐ F ☐ Other___Pronouns: _____ Social Security #: *____ - ___ - ____

Mailing Address: _____

City: _____ State: _____ Zip: _____ E-mail Address: _____

Phone #: ** ☐ Home _____ ☐ Cell _____ ☐ Work _____

Employer: _____ Occupation: _____

Status: ☐ Minor ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

If Married, Spouse's Name: _____ # of Children: _____

Emergency Contact: _____ Phone #: _____

Whom may we thank for referring you? _____

**Optional **Check best contact number*

SECTION 2. PAYMENT (select one)

☐ **Insurance** Insurer's Name (if other than self): _____ Insurer's DOB: ____ / ____ / ____

Primary: _____ Policy #: _____Secondary: _____ Policy #: _____

☐ **Auto/Personal Injury** Auto Insurance Carrier: _____ Policy #: _____

Claim #: _____ Adjuster's Name: _____

Adjuster's Ph. #: _____ Adjuster's Fax #: _____

Attorney Name (*If Applicable*): _____ Attorney Phone #: _____

☐ **Self-Pay** ☐ **Other** *(Please Specify)* _____

SECTION 3. HEALTH HISTORY

Primary Care Physician: _____ Phone #: _____

Are you Taking Any Medications? ☐ Yes ☐ No If yes, please list _____ HEIGHT: WEIGHT:

_____

Have you ever had an MRI of your spine? ☐ Yes ☐ No If yes, when _____

Do you have or ever had any of the following diseases or conditions? *(mark: **y** for yes **n** for no)*

☐ Alcohol/drug abuse	☐ Congenital heart defect	☐ Frequent neck pain	☐ Joint Pain	☐ Sciatica
☐ Anemia	☐ Diabetes/tuberculosis	☐ Heart attack/stroke	☐ Kidney problems	☐ Severe/frequent headaches
☐ Arthritis	☐ Difficulty breathing	☐ Heart murmur	☐ Leg/Arm Pain	☐ Shingles
☐ Artificial bones/joints	☐ Dislocations	☐ Heart surgery/pacemaker	☐ Lower back problems	☐ Sinus problems
☐ Artificial valve	☐ Emphysema/Glaucoma	☐ Herniated Disc	☐ Mitral valve prolapse	☐ Snoring
☐ Asthma	☐ Fainting/seizures/epilepsy	☐ High/low blood pressure	☐ Psychiatric diagnoses	☐ Ulcer/colitis
☐ Cancer/Chemotherapy	☐ Fractures	☐ HIV/AIDS	☐ Rheumatic fever	☐ Venereal disease

List any other serious medical condition(s) that we should know about: _____

_____

List any past serious accidents or surgeries and include the dates: _____

_____

List allergies: _____

Do you exercise? ☐ Yes _____times/day ☐ No What exercise activities do you do? _____

Do you: • smoke? ☐ Yes _____times/day ☐ No • drink alcohol? ☐ Yes _____times/week ☐ No • drink coffee? ☐ Yes _____cups/day ☐ No

Do you take supplements (i.e. vitamins, minerals, herbs)? List them: _____

FOR WOMEN: Have children? ☐ Yes ☐ N Taking birth control? ☐ Yes ☐ No Pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

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SECTION 4. REASON FOR VISIT

The reason for this visit is a result of ☐ Work ☐ Auto ☐ Trauma ☐ Chronic ☐ Other *(Explain)*: _____

_____

Please describe the pain and its location: _____

When did the condition begin? _____ This condition is: ☐ Constant ☐ Intermittent ☐ Activity related

Condition is interfering with: ☐ Work ☐ Sleep ☐ Hobbies ☐ Daily routine If so please explain: _____

What activities aggravate your symptoms? _____ Condition getting worse? ☐ Yes ☐ No

Is there anything, which has relieved your symptoms? ☐ Yes ☐ No *(Describe)* _____

Have you experienced this condition before? ☐ Yes ☐ No If so please explain: _____

Who have you seen for this? _____

What did they do? _____ How did you respond? _____

Are there activities you cannot do as a result of your problem/pain? ☐ Yes ☐ No *(Describe)* _____

Check what most describes your pain? *(Mark: **y** for yes **n** for no)*

Aching	Cramping/Spasm	Sharp	Pin/Needles
Hot/Burning	Numbing	Throbbing	Shooting
Pressure	Stabbing	Dulls	Tingling

Rate your pain at its worst:
No pain 1 2 3 4 5 6 7 8 9 10 Excruciating

Rate your pain at its best:
No pain 1 2 3 4 5 6 7 8 9 10 Excruciating

Rate your pain on average:
No pain 1 2 3 4 5 6 7 8 9 10 Excruciating

Rate your pain now:
No pain 1 2 3 4 5 6 7 8 9 10 Excruciating

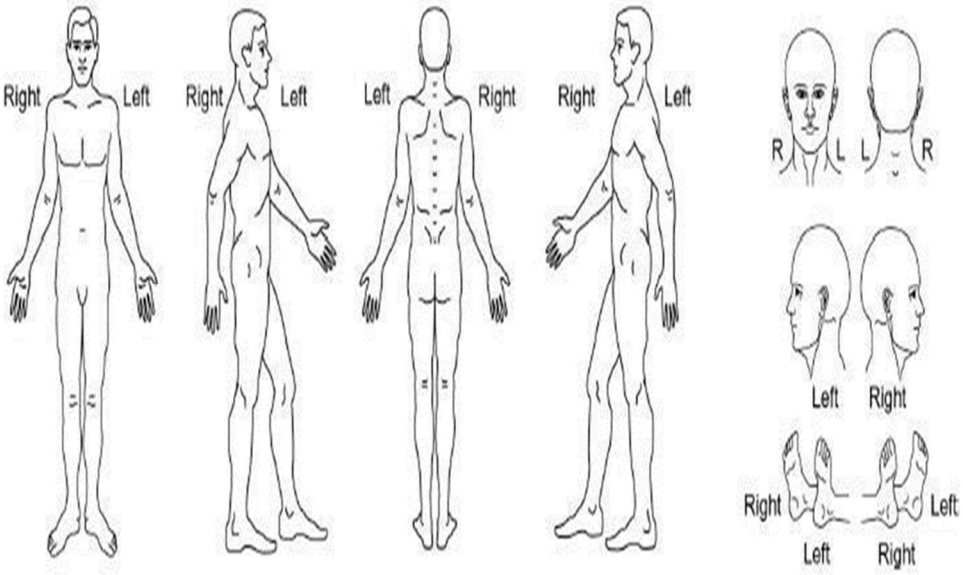
What makes your pain worse? *(Please put a X)*

Bending	Changing Position	Defecation	Going upstairs	Going downstairs	Heat	Increased Activity
Lying Flat	Lifting	Movement	Sitting long time	Sneezing	Standing Long	Standing straight
Turning to the left	Turning to the right	Turning side to side	Walking			

What Makes your pain better? *(Please put a X)*

Assistive devices	Changing Position	Cold	Heat	Exercise
Injections	Massage	Manipulation	Medication	Physical Therapy
Rest	Sitting	Standing	Walking	Lying Flat

On the diagram, please shade in the areas where you have pain?



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SECTION 5. CHIROPRACTIC HISTORY (if applicable)

What is your goal here at Bethesda Spine & Posture?

_____

Have you ever been treated by a chiropractor before? ☐ Yes ☐ No If so, whom? _____ When? _____

Did your previous chiropractor take before and after x-rays? ☐ Yes ☐ No

	1= No pain									10= Worst pain imaginable
Please circle the number corresponds with your pain today overall.	1	2	3	4	5	6	7	8	9	10
Please circle the number corresponds with your pain at its worst.	1	2	3	4	5	6	7	8	9	10

Is there any time during the day that you have no pain? ☐ Yes ☐ No

Do you ever "pop or crack" your own neck or back? ☐ Yes ☐ No

Do you snore at night? ☐ Yes ☐ No Do you ever experience numbness or tingling in your hands/feet? ☐ Yes ☐ No

Do your feet ever bother you? ☐ Yes ☐ No Do you sometimes feel like one leg is longer than the other? ☐ Yes ☐ No

Is there any anything else we should know, or you'd like to add? _____

SECTION 6. RADIOGRAPH CONSENT, APPOINTMENT POLICY, AUTHORIZATION FOR TREATMENT

I _____ hereby give my consent to allow Bethesda Spine & Posture and its representatives as deemed by the examining physician to take radiographs (x-rays) of my spine and/or extremities.

For Women: I also hereby declare that to my knowledge I am not pregnant _____ (Initial)

Signature of Patient or Guardian of said Minor _____ Date _____

If you miss appointments without prior notification will result in a $25.00 cancellation fee. We apologize for any inconvenience this may cause, but each patient's time with the doctor/therapist is valuable. If you need to reschedule your appointment, kindly give us a courtesy phone call, so we are able to open up the timeslot for other patients.

Signature of Patient or Guardian of said Minor _____ Date _____

I authorize and agree to allow the doctor and/or physical therapist to examine and treat me for the purpose of postural and structural restoration of normal biomechanical, neurological function, and reduction of pain.

The doctor and/or physical therapist will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the medical and spinal structural conditions diagnosed at this clinic. I authorize the assignment of all insurance benefits to be directed to the doctor and/or physical therapist for all services rendered.

Signature of Patient or Guardian of said Minor _____ Date _____

SECTION 7. PAYMENT POLICY, INSURANCE POLICY

1. You are considered to be a cash patient until our office qualifies your coverage to determine the extent of benefits under your policy. As a COURTESY, our office will file your claim with your insurance company, and initiate correspondence with the purpose of getting you the maximum coverage your insurance will allow; however, the payment is ultimately your responsibility.
2. All deductible payments must be made prior to insurance submittal. Please contact your insurance company to verify your coverage.
3. All co-payments must be paid in full at the time of service.
4. Should you discontinue care for any reason other than discharge by the doctor, any and all balances due will become immediately payable in full, regardless of any claims submitted.
5. This office does not promise that insurance company will reimburse you for the usual and customary charges submitted by this office, nor will we enter into any dispute with an insurance company over the amount of reimbursement.

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In order to keep our fees from rising and at the same time keep up with the monumental expenses of bookkeeping and billing services, we have opted to offer our patients these payment policies.

1. Payment is expected at the time services are rendered. Our office accepts cash, Visa, Mastercard, Discover, American Express, and checks.
2. Non-insured patients are expected to make payments in full on the day the service is rendered unless definite arrangements have been made with the doctor in advance.
3. Patients with insurance are expected to pay their patient portion of the total fee not covered by their insurance on the day of service. This "patient portion" is ONLY an estimated dollar amount.
4. At your request, the doctor will discuss the charges with you before care begins.

We bill patients on a monthly basis. All accounts not paid within 90 days will automatically be put through to an outside collections' agency, which may affect your credit. In case of financial difficulty, please let us know so that a manageable payment schedule can be worked out.

Signature of Patient or Guardian of said Minor _____ Date _____

SECTION 8. NOTICE OF PRIVACY PRACTICES

The following authorizes Bethesda Spine & Posture to use and/or disclose protected health care information in accordance with the following specific authorizations:

I give permission to Bethesda Spine & Posture to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective healthcare information during the course of my treatment. Should I need to speak with the doctor/physical therapist in private, the doctor/physical therapist will provide a private room for these conversations.

By signing the following you are giving Bethesda Spine & Posture permission to use and disclose your protected health information in accordance with the directives listed in the "Authorization for Treatment" section. Information you provide may be used for:

- Treatment
- Payment
- Appointments

_____ (Initial) I authorize Bethesda Spine & Posture to notify me of appointments by email or text appointment reminders, per my request. And I authorize Bethesda Spine & Posture to email my x-rays and medical records, upon my request. I understand that records sent through unencrypted email pose a security risk, but it is my requested method.

_____ (Initial) I understand and have been provided with a notice of information practices that provides me with a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health care information for directory purposes
- The right to request restrictions as to how my health care information may be used or information may be used or disclosed in this office to carry out treatment, payment, or health care operations.

Signature of Patient or Guardian of said Minor _____ Date _____

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CHIROPRACTIC SERVICES - INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic services and other procedures within the scope of the practice of chiropractic on me (or on the patient named below, for whom I am legally responsible) by the chiropractor named below and/or other licensed chiropractor who now or in the future treat me while employed by, working or associated with or serving as back-up for the chiropractor named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not. I understand that the primary treatment used by Doctor of Chiropractic is spinal manipulative therapy. He or she may use her hands or mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles.

I understand that methods of treatment may include, but are not limited to, spinal manipulative therapy, palpation, instrument adjustments, range of motion testing, orthopedic testing, neurological testing, muscle strength testing, postural analysis testing, laser therapy, assisted isolated stretching, exercises, power plate exercises, cryotherapy, electric muscle therapy, and traction therapy. I have been informed that chiropractic treatment is a generally safe method of treatment, but that it may have some side effects, as with any other healthcare procedure. As with any other healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy that are very rare such as fractures or minor muscle pulls.

It is common to feel stiffness or soreness following the first few days of treatment. Fractures are very rare occurrences and generally result from some underlying weakness of the bone. Stroke or vertebral artery dissection caused by chiropractic manipulation of the neck has not been officially proven but continues to be anecdotal. The doctor will make every reasonable effort during the examination to screen for contraindications to care, however if you have a condition that would not come to the Doctor's attention, it is your responsibility to inform the doctor. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent. By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of chiropractic treatment and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name: _____

Signature of Patient/Legal Representative/Guardian of said Minor:

_____

Provider: I certify that I have explained to the patient (or legally responsible agent) his/her condition, the proposed operation(s)/treatment(s) attendant risk and possible discomforts involved, other methods of treatment, and the possibility of complications.