Welcome to FERREL'S CHIROPRACTIC!

Please fill out the information below as completely and accurately as possible. Additional information at the bottom of this form is optional. However, it will help us to better serve your needs and ensure that you have the best possible experience in our office!

PERSONAL INFORMATION

NAME____DATE__________________________________

ADDRESS:___________________________________CITY____________________ZIP_______________

PHONE:_____________________(H) ________________________(W) _____________________(C)

EMAIL ADDRESS___________________________

DATE OF BIRTH:___________________________ AGE______ SS#______________________________

EMPLOYER:______________________________ OCCUPATION_____________________________

INSURANCE CARRIER:_______________________________POLICY #__________________________

GROUP #_______________________

PRIMARY CARE PROVIDER/FAMILY DOCTOR'S NAME:___________________________________

Is your complaint: sports related work related personal injury/auto accident other

If personal injury, attorney name/address/phone:____
____

Are you interested in (check all that apply)

- Symptom/pain relief
- Rehabilitation/Restoration/Return to play
- Prevention/Development
- Performance enhancement

OPTIONAL INFORMATION:

Spouse_____________________________________ Pets_________________________________
Children____
Sports____
Hobbies/interests____

How did you hear about Ferrel's Chiropractic?

What are your expectations and/or goals for care?

Name____**Date**______________

Current Health Concern____
Date of Onset____
Cause of Injury____

Pain Description
☐Sharp ☐Dull
☐Ache ☐Cramp
☐Spasm ☐Stabbing
☐Shooting ☐Radiating
☐Local ☐Pinpoint
☐Referred ☐Burning
☐Throbbing ☐Deep
☐Tingling ☐Numbness

Length of day in pain
☐Intermittent (<25%) ☐Frequent (>50%)
☐Occasional (>50%) ☐Constant (>75%)

Pain interference with activities
☐Minimal(annoy) ☐Moderate(impair)
☐Slight(tolerate) ☐Marked(preclude)

What makes it better?
☐Lying down ☐Standing
☐Walking ☐Anti-inflammatory pills
☐Muscle relaxant ☐Injections

What makes it worse?
☐Exercise ☐Bending Forward
☐Bending Back ☐Sitting
☐Standing ☐Walking
☐Coughing ☐Sneezing
☐Other_________________________________
____
____

Care to Date
☐None ☐Self
☐Other HCP___________ ☐RX Meds______________
☐OTC Meds___________ ☐Surgery______________
☐Rest ☐Physical Therapy

Testing
☐X-Ray ☐MRI
☐CT Scan ☐Ultrasound
Results________________________________
____
____

Related Problems
☐headache ☐dizziness
☐visual disturbance ☐ringing in ears
☐short of breath ☐chest pain/tightness
☐back ache ☐shoulder pain
☐flank pain ☐groin pain
☐stomachache ☐nausea
☐vomiting ☐intestinal pain
☐pain-urination ☐difficulty-urination
☐pain-defecation

Have you ever experience this pain before?
☐Yes ☐No
If yes, when and what was the outcome?
____
____
____

What medications are you currently taking?
____
____
____

Allergies: ☐Yes ☐No
Smoker: ☐Yes ☐No

Current Status
☐Worsening ☐Improving
☐No Change ☐Slight
☐Moderate ☐Significant

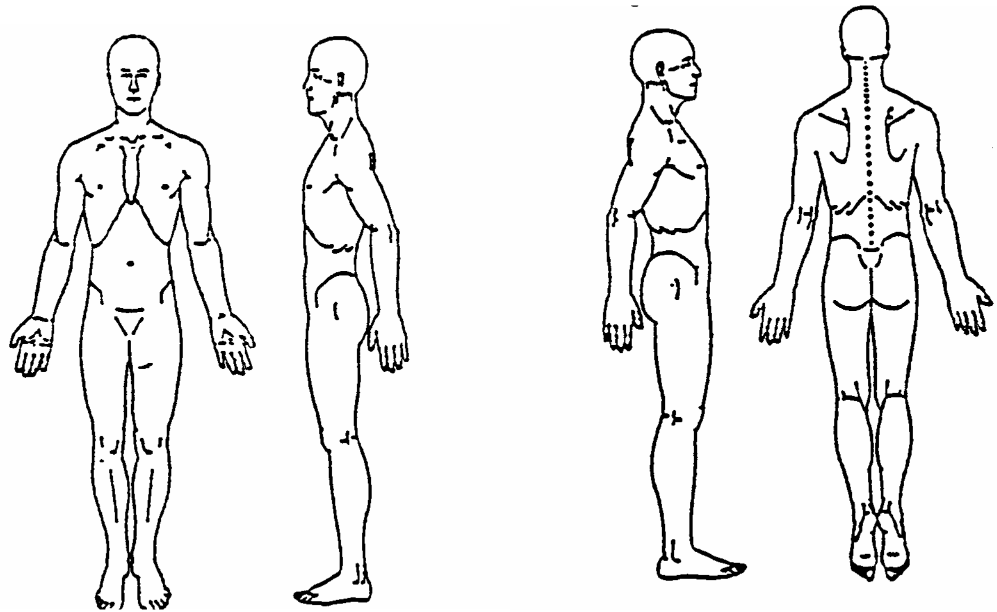
Goals for Care
☐Symptom Relief ☐Rehabilitation
☐Prevention ☐All

Ferrel's Chiropractic Pain Chart-page 3

Name:____ **Date:**____________________

Please use the picture at right to diagram the quality and location of today's pain.

achy and dull	**A**
stiffness	**T**
burning	**B**
sharp and stabbing	**S**
pins and needles	**P**
numbness	**N**



0. Pain Free
1. Very minor annoyance - occasional minor twinges.
2. Minor annoyance - occasional strong twinges.
3. Annoying enough to be distracting.
4. Can be ignored if you are really involved in your work, but still distracting.
5. Can't be ignored for more than 30 minutes.
6. Can't be ignored for any length of time, but you can still go to work and participate in social activities.
7. Makes it difficult to concentrate, interferes with sleep. You can still function with effort.
8. Physical activity severely limited. You can read and converse with effort. Nausea and dizziness set in as factors of pain.
9. Unable to speak. Crying out or moaning uncontrollably - near delirium.
10. Unconscious. Pain makes you pass out.

Please circle the number below that corresponds with your pain today.

Please circle below the frequency of your pain today?

OCCASIONAL	**INTERMITTENT**	**FREQUENT**	**CONSTANT**
0-25%	**25-50%**	**50-75%**	**75-100%**

Please answer each section by circling the ONE CHOICE that most applies to you. You may feel that more than one statement relates to you, but only circle the one choice that closely describes your problem right now.

SECTION 1 - Pain Intensity

A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2 -Personal Care

A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
D. Washing and dressing increase the pain, but I manage not to change my way of doing it.
E. Because of the pain, I am occasionally unable to do any washing and dressing without help.
F. Because of the pain, I am always unable to do any washing or dressing without help.

SECTION 3 - Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it gives extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned, e.g. on the table
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

SECTION 4 - Walking

A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than one mile.
C. Pain prevents me from walking more than ½ mile.
D. Pain prevents me from walking more than ¼ mile.
E. I can only walk while using a cane or crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – Sitting

A. I can sit in any chair as long as I like without any pain.
B. I can only sit in my favorite chair as long as I like despite pain.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than ½ hour.
E. Pain prevents me from sitting more than 10 minutes.
F. Pain prevents me from sitting at all.

SECTION 6 - Standing

A. I can stand as long as I want without pain.
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I can't stand for more than 10 minutes without increasing pain.
F. I cannot stand at all due to pain.

SECTION 7 -Sleeping

A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping.
C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8 – Social Life

A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests. e.g. dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. Pain prevents me from social activity at all.

SECTION 9 - Traveling

A. I get no pain while traveling.
B. I get some pain while traveling, but none of my usual forms of travel makes it any worse.
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain prevents all forms of travel except that done lying down.

SECTION 10 – Changing Degree of Pain

A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

SECTION 11 - Work

A. I can do as much work as I want.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do my work at all.
F. I cannot do any work at all.

SECTION 12 – Reading

A. I can read as much as I want with no pain.
B. I can read as much as I want with slight pain.
C. I can read as much as I want with moderate pain.
D. I cannot read as much as I want because of moderate pain.
E. I cannot read as much as I want because of severe pain.
F. I cannot read at all due to pain.

Patient Name: ___________________________ **Patient/Other Signature: ___________________________**

Date ____/___/____ **Relationship to Patient:____________________________**

DIFFICULTY IN PERFORMING ACTIVITIES OF DAILY LIVING

PATIENT NAME:____

Check each of the activities which you have difficulty performing and/or can perform only with pain. (There is no particular priority in the order presented).

HOUSEWORK

- ____ **Doing Laundry**
- ____ **Making Beds**
- ____ **Vacuuming**
- ____ **Washing Dishes**
- ____ **Ironing**
- ____ **Carrying Groceries**
- ____ **Caring for Pets**
- ____ **Cooking**
- ____ **Other________________________**

YARD WORK

- ____ **Mowing Lawn**
- ____ **Shoveling Snow**
- ____ **Raking Leaves**
- ____ **Gardening**

GENERAL

- ____ **Walking**
- ____ **Standing**
- ____ **Running**
- ____ **Sitting**
- ____ **Lifting Children**
- ____ **Bending**
- ____ **Climbing Stairs**
- ____ **Reading**
- ____ **Lying in Bed**
- ____ **Chewing**
- ____ **Swimming**
- ____ **Sports: List____**

PERSONAL GROOMING

- ____ **Combing Hair**
- ____ **Shaving**
- ____ **In/Out Bathtub**
- ____ **Brushing Teeth**
- ____ **Other_______________**

TRAVEL

- ____ **Driving**
- ____ **Riding (passenger)**

Minutes per day

Type of Vehicle

- ____ **Automobile**
- ____ **Train**
- ____ **Bus**
- ____ **Airplane**

- ____ **Getting in/out of auto**
- ____ **Playing Piano**
- ____ **Using Typewriter/computer**
- ____ **Kneeling**
- ____ **Sexual Intercourse**
- ____ **Exercising**
- ____ **Sleeping**
- ____ **Using Telephone**
- ____ **Sitting in recliner**

OTHER: **Please list any other difficulties you are experiencing with activities you have engaged in since your condition arose:__________________________________**

____

____

Signed:____ **Date_____________________**

Acceptance of Terms & Consent to Care

Medicare Limits and Responsibilities
The only charge for chiropractic that is covered is manipulation of the spine. I accept responsibility to know the current Medicare guidelines and limits for covered services. I understand that Medicare may reimburse me for chiropractic adjustments, and that the Medicare program frequently does not consider treatments to me medically necessary. I accept responsibility to pay for all covered, non-covered and denied services. My physician has notified me that he or she believes that in my case Medicare is likely to deny payment for some or all services. If Medicare denies payment, I agree to be personally and fully responsible for payment. I understand that I must pay for services at the time of service. I also understand that Ferrel's Chiropractic will bill all charges directly to Medicare as required by law. I authorize the release of my records as necessary for Medicare billing.

Statement of Acknowledgement of Financial Responsibility
I understand that I may be responsible for any charges incurred at this office, including co-pays, deductibles, and any services denied or not covered by my insurance company. I realize my care may be subject to pre-authorization by the insurance company, and I accept any responsibility for charges not approved. The insurance company will review any/all documentation submitted by Ferrel's Chiropractic for their assessment of medical necessity and base their approval/denial upon this documentation.

I understand that this office agrees to notify me as soon as possible if a service is not covered and will notify me if my insurance company does not approve my care. If a treatment plan is approved, this office will make me aware of the number of office visits allowed and the time frame of the authorization. Initial visits may be denied and this may be beyond the office's ability to notify the patient prior to rendering acute care, while waiting for insurance coverage approval. These charges will be the patients' responsibility if denied by the insurance company.

This office may seek payment from myself for any services my health insurance determines to be not medically necessary or not covered by my plan. Signing below indicates that I have read and understand my obligations for payment for care in the absence of insurance coverage.

Informed Consent/Consent to Treat
I have been informed of the nature, purpose and scope of care to be provided by Dr. Ernest W. Ferrel, D.C., the possible limitations and consequences of that care, and the possibility that the care given by Dr. Ferrel may not completely resolve my complaint, dysfunction or condition. I consent to care and recommendations made by Dr. Ferrel for myself (or my children, if minors) including, but not limited to examinations, x-rays, chiropractic adjustments, adjunctive therapies and rehabilitation. I understand that my care will be individualized and therefore may not be comparable with standards or guidelines required by insurance companies, Medicare, professional associations and/or consensus groups. I understand that my treatment will comply with the standard of care defined by the laws in the State of California. I recognize that all health care procedures, including those used in this office, have risks associated with them. Risks, although rare, associated with chiropractic adjusting procedures may include minor aggravation of symptoms, musculoskeletal sprain/strain, neurological deficits, osseous fracture, vertebral artery syndrome, including cerebrovascular accident (stroke) or death through complicating factors. I hereby accept the risks associated with any care by Dr. Ferrel of Ferrel's Chiropractic and release Ferrel's Chiropractic of any liability for any injury or loss directly related to care I have received at this clinic.

I am signing this consent and acceptance of terms after having been fully informed to my satisfaction of the risks and benefits of proceeding with care and declining care. I have been informed and fully understand that there are not guarantees of treatment success. By my presence and continuation of appointments, I consent and elect to care provided by Ferrel's Chiropractic.

____
Patient Name (please print)

____
Patient Signature　　　　　　　　　　　　Date

I have reviewed the above terms of acceptance and consent with the patient named above and I am satisfied that he/she fully understands the nature and content of the agreement.

____
Doctor Signature　　　　　　　　　　　　Date

CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND/OR HEALTHCARE OPERATIONS

Through the use of this consent form, Ferrel's Chiropractic, (referred to as the or this "office") is notifying you and you agree that:

1. Protected health information may be used and/or disclosed in order to carry out treatment, payment or healthcare operations.

2. If you do not consent to the above use and/or disclosure, Federal Rules do not require or oblige this office/practice to treat you in the absence of your consent.

3. A notice containing the office's privacy practice, including a more complete description of uses and/or disclosures necessary to carry out treatment, payment and/or healthcare operations, is available for you to read, and you are hereby encouraged to do so prior to signing this consent form.

4. The following appointment reminders may be used by this office: a)a postcard mailed to you at the address provided by you, b)telephoning your home and leaving a message on your answering machine or with the individual answering the phone or c) email.

5. This office reserves the right to change its privacy practices that are described in the above referenced notice, in accordance with applicable law, and will make available to all patients any and all revised and current notices.

6. You have a right to request that this office restrict how protected health information is used and/or disclosed to carry out treatment, payment and/or healthcare operations.

7. This office is not required to agree to any restrictions on your health information that you have requested.

8. If this office agrees to a requested restriction, then the restriction will be binding on this office/practice.

9. This consent is valid for seven years. You have the right to revoke this consent, in writing, at any time for all future transactions with the understanding that any revocation will not apply to the extent that this office/practice has already taken action in reliance of a previously signed consent.

10. Should you revoke this consent at any time, the office retains its right to refuse treatment based upon the revocation and the future lack of such consent.

11. You must sign and date all consents and authorizations requested to which you agree.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

______________________________	______________________________
Name of Patient/Individual (please print)	Signature of Patient/Individual
______________________________	______________________________
Signature of Legal Representative (e.g. Attorney-In-Fact, Guardian, Parent (if minor)	Relationship to Patient
______________________________	______________________________
Date Signed	Witness

FERREL'S CHIROPRACTIC
~FINANCIAL POLICY~

Group or Individual Health Insurance

Health Insurance is an agreement between you and your insurance company, not between your insurance company and this office. As a courtesy to our patients, our office will complete any necessary reports and forms at **no charge to you,** and then file them with your insurance company. It is to be understood and agreed that services rendered are charged to you and your insurance company. Should your insurance carrier deny payment, you are personally responsible. Insurance companies typically take 3-4 weeks to send payment to our office. **If after 60 days our office has not received payment from the insurance company, you will be billed directly for the outstanding balance due.**

Patients without Insurance

Payment is due at the time that services are received unless other payment arrangements have been made. Should the need arise, please contact us immediately to discuss a mutually agreeable payment plan.

"On the Job" Injury

We will gladly bill your care directly to your employer's insurance company, providing that we have received all forms related to your injury. Please understand that you must first report any work related injury to your employer and then follow the necessary steps to file a claim with your employers insurance.

Personal Injury and Automobile Accidents

We will gladly bill your care directly to the responsible party. Please present all forms related to your accident, including claim numbers from the insurance company. If an attorney is handling your case, please notify us immediately.

Missed Appointments

Not showing for your appointment if a problem for everyone. It delays your treatment, prevents another patient from coming in your place, and costs the office a great deal. Failing to contact this office **24 hours prior to your appointment can result in a charge for that missed appointment.** This charge is solely your responsibility and not your insurance company's. Additionally, if you arrive late for a scheduled appointment, we reserve the right to ask you to reschedule. Please help us serve you better by keeping scheduled appointments.

Collection of Past-Due Accounts

We make every effort to keep accounts from falling behind, and are willing to work with every individual in order to avoid the use of third-party collection specialists. If we must retain an attorney or collection company, the patient and/or guardian is responsible for all costs incurred with this process, including the attorney's fee, court costs, and filing fees. **Accounts that are 90 days past due will be assessed a 3% per month service charge.**

I, the undersigned, have read and agree with the above policy.

____ __________________

Patient/Guardian Signature **Date**

____ __________________

Witness Signature **Date**

Ferrel's Chiropractic

Dear Patient:

Our financial policies have been established to ensure that the best services can be provided to you and your family and any misunderstanding can be avoided.

Our professional services are rendered to the patient and not the insurance company. The insurance company is responsible to the patient and the patient is responsible to the doctor. We will not provide services on the assumption that the charges will be paid for full payment of your bill. We will verify your insurance eligibility and, as a courtesy, submit your claim into your insurance carrier for payment. We will not be held responsible for any misinformation your insurance carrier gives this office upon verification of your benefits.

……………………………………………………………………………………………

I understand that any expected payment from my insurance company is an **ESTIMATE** only and that no balance shall be carried by Ferrel's Chiropractic. I also understand that I am responsible for any portion not covered by my insurance at the day the services are rendered. If I do not have coverage under medical insurance, payment in full is due at the time services are rendered.

____________________________________ __________________

Patient or Guardian’s Signature Date