Welcome to Vermillion Chiropractic, P.C.

Financial Agreement and Office Policies

Notice: Everything done in this office whether for diagnostic or treatment purposes is a valuable and billable service and it is the patient's responsibility to know what chiropractic services their insurance covers . If you do not understand why a procedure is being done or have a question of the cost of a service please ask. We are happy to explain the purpose and cost of any service. If you make an advance appointment and for some reason you must miss your appointment, it is **your responsibility** to notify this office at least **1 hour** before your appointment time or Vermillion Chiropractic, P.C. reserves the right to charge your account for the missed office visit. If your account is 30 days past due, Vermillion Chiropractic, P.C. reserves the right to add a service charge of up to 20% per annum or $1.50 per month to your total remaining balance.

____ I will pay any insurance indicated co-pay or deductible fees that are due after each office visit or after an explanation of benefits has been received from the insurance company. **I understand that it is my responsibility to know what my chiropractic insurance benefits are.**

____ I have no health insurance or health insurance will not cover Chiropractic care and will pay full balance after each visit.

____ I will provide Vermillion Chiropractic, P.C. with auto insurance for billing, understanding that I am ultimately responsible for payment of all charges that may accrue to my account.

____ Worker's compensation claims will be billed accordingly under the patient's work comp. insurance with the understanding that if any service is denied the patient is personally responsible for their account balance unless other agreements have been made.

____ Medicare will cover the adjustment fee only. Medicare does not cover exam, x-ray or any other service provided by this office. All services will be billed to Medicare and patient's supplemental insurance.

____ Medicaid patient will pay $1.00 per visit for an adult. There is no co-pay for children under 18 years of age.

Patient Contact Information

Name:_____ SSN:_____ Date: _____
Address: _____ City:_____ State: _____ Zip: _____
Sex: Male Female Date of Birth: _____ Age: _____
Home Phone: _____ Work Phone:_____ Cell Phone:_____
Single Married Divorced Widowed **E-Mail(contact purposes only)**:_____
Employer: _____ Occupation: _____
Address: _____City: _____ State: _____ Zip: _____
Spouse's or Parent's Name: _____
How did you find out about our office? _____
Emergency contact: _____ Number: _____

By signing, I have read and understand all information contained in this document that pertains to my account with Vermillion Chiropractic, P.C. and I authorize the release of necessary information for review by any third party responsible for payment where applicable.

Patient Signature _____ Date _____

Patient Intake Questionnaire

List any **Allergies**:

□ Animals □ Aspirin □ Bees □ Chocolate □ Dairy □ Dust □ Eggs□ Latex □ Molds □ Penicillin □ Ragweed/Pollen

□ Rubber □ Seasonal Allergies □ Shellfish □ Soaps □ Wheat □ X-Ray Dye □ Other: _____

List any **Surgeries**:

□ Back □ Brain □ Elbow □ Foot □ Hip □ Knee □ Neck □ Neurological □ Shoulder □ Wrist □ Other: _____

□ None

List **ALL Past Medical History** conditions:

□ Ankle Pain □ Arm Pain □ Arthritis □ Asthma □ Back Pain □ Broken Bones □ Cancer □ Chest Pain □ Depression

□ Diabetes □ Dizziness □ Elbow Pain □ Epilepsy □ Eye/Vision Problems □ Fainting □ Fatigue □ Foot Pain

□ Genetic Spinal Condition □ Hand Pain □ Headaches □ Hearing Problems □ Hepatitis □ High Blood Pressure

□ Hip Pain □ HIV □ Jaw Pain □ Joint Stiffness □ Knee Pain □ Leg Pain □ Menstrual Problems □ Mid-Back Pain

□ Minor Heart Problem □ Multiple Sclerosis □ Neck Pain □ Neurological Problems □ Pacemaker □ Parkinson's

□ Polio □ Prostate Problems □ Shoulder Pain □ Significant Weight Change □ Spinal Cord Injury □ Sprain/Strain

□ Stroke/Heart Attack □ Other: _____

List **Names of Medications/Dietary Supplements** you are taking: □None 1._____2._____3._____

4. _____ 5._____ 6._____ 7._____

Reason: □ Anxiety □ Muscle Relaxors □ Pain Killers □ Insulin □ Birth control □ Cardiovascular □ Allergy □ Seizure

List your **Family History**:

□ Arthritis □ Asthma □ Back Pain □ Cancer □ Depression □ Diabetes □ Epilepsy □ Genetic Spinal Condition

□ High Blood Pressure □ Heart Problems □ Multiple Sclerosis □ Neurological Problems □ Parkinson's □ Polio

□ Prostate Problems □ Stroke/Heart Attack □ Other: _____

What is your favorite position to sleep in?: □ Back □ Side □ Stomach

How much water do you drink per day? _____oz.

Have you had any auto or other accidents? □ No □Yes

Describe: _____

Date of last physical examination: _____ Do you smoke? □ No □Yes

Do you drink alcohol? □ No □Yes - how many per day? _____

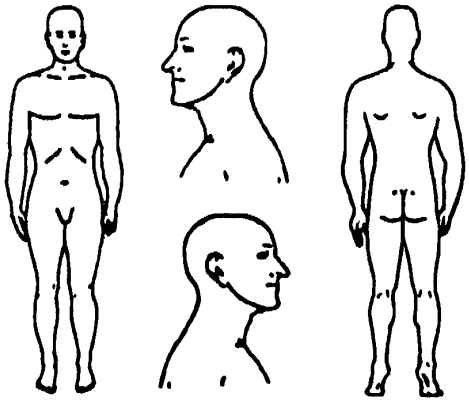
Do you drink caffeine? □ No □Yes - how many per day? _____

Do you exercise? □ No □Yes (what forms and how often): _____

Very Important

Have you ever had chiropractic care? No Yes
When? _____Why? _____
Where? _____
Were X-rays taken? No Yes
When was your last adjustment? _____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM



What is your major complaint? _____
Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

Have you had this condition in the past? YES - NO

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

How intense is the pain? □ Minimum □ Mild □ Moderate □ Severe □ Unbearable

Describe the nature of your symptoms: □ Burning □ Dull □ Numb □ *Radiating/Traveling □ Sharp □ Shooting □ Stabbing

□ Tightness □ Tingling □ Throbbing □ **If radiating or traveling, where does the pain travel too? _____

What makes your pain better? □ Chiropractic Therapy □ Heat □ Ice □ Pain Medicines □Slept/Rest □ Stretching □ Exercises

What do you expect out of your visit today?

□ Become pain free □ Reduce Symptoms □ Resume Normal Activity □ Learn how to manage condition

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

What activities aggravate your condition (working, exercise, etc)? _____

What made you choose chiropractic as a treatment for your condition?_____

What is your SECOND complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

Have you had this condition in the past? YES - NO

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

How intense is the pain? □ Minimum □ Mild □ Moderate □ Severe □ Unbearable

Describe the nature of your symptoms: □ Burning □ Dull □ Numb □ *Radiating/Traveling □ Sharp □ Shooting □ Stabbing

□ Tightness □ Tingling □ Throbbing □ **If radiating or traveling, where does the pain travel too? _____

What makes your pain better? □ Chiropractic Therapy □ Heat □ Ice □ Pain Medicines □Slept/Rest □ Stretching □ Exercises

What do you expect out of your visit today?

□ Become pain free □ Reduce Symptoms □ Resume Normal Activity □ Learn how to manage condition

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

What activities aggravate your condition (working, exercise, etc)? _____

What made you choose chiropractic as a treatment for your condition?_____

Pain Questionnaire

Pain Intensity:

0 I have no pain.
1 Pain comes and goes and is very mild.
2 Pain is constant and is very mild.
3 Pain comes and goes and is moderate.
4 Pain is constant and is moderate.
5 Pain is constant and is severe.

Personal Care:

0 I look after myself normally w/o causing extra pain.
1 I look after myself normally but it causes extra pain.
2 It's painful looking after myself; I am slow/careful.
3 I need help but manage most of my personal care.
4 I need help every day in most aspects of self-care.
5 I don't get dressed, was w/difficulty, stay in bed.

Lifting:

0 I can lift heavy weight w/o extra pain
1 I can lift heavy weight but it causes extra pain.
2 Pain prevents me from lifting heavy weights but I can manage if they are conveniently positioned.
3 Pain prevents lifting heavy weights but I can manage medium conveniently positioned weights.
4 I can only lift very light weights.
5 I cannot lift or carry anything at all.

Walking:

0 Pain does not prevent me walking any distance
1 Pain prevents me from walking more than one mile.
2 Pain prevents me from walking more than ½ mile.
3 Pain prevents me from walking more than ¼ mile.
4 I can only walk using a cane or crutches.
5 I am in bed most of the time and crawl to the toilet.

Sitting:

0 I can sit in any chair as long as I like.
1 I can only sit in my favorite chair as long as I like.
2 Pain prevents me from sitting for more than 1 hour.
3 Pain prevents me from sitting for more than ½ hour.
4 Pain prevents me from sitting for more than 10 min.
5 I avoid sitting as it increases my pain straight away.

Standing:

0 I can stand as long as I want w/o extra pain.
1 I can stand as long as I want but w/ extra pain.
2 Pain prevents standing for more than 1 hour.
3 Pain prevents standing for more than ½ hour.
4 Pain prevents standing for more than 10 min.
5 Pain prevents me from standing at all.

Sleeping:

0 I have no trouble sleeping.
1 I can only sleep well by taking medications.
2 I get less than 6 hrs before the pain wakes me.
3 I get less than 4 hrs before the pain wakes me.
4 I get less than 2 hrs before the pain wakes me.
5 Pain prevents me from sleeping at all.

Changing Degree of Pain:

0 My pain is decreasing and I am getting better.
1 My pain fluctuates but I am getting better.
2 My pain is decreasing; improvement is slow.
3 My pain is not changing – not better or worse.
4 My pain is increasing; gradually getting worse.
5 My pain is rapidly increasing – getting worse.

Social Life:

0 My social life is normal and no extra pain.
1 My social life is normal but increases pain.
2 Pain has no significant effect on my social life apart from limiting more energetic interests.
3 Pain restricts my social life; I don't go out often.
4 Pain has restricted my social life to my home.
5 I have no social life because of pain.

Pain Intensity:

0 I can travel anywhere w/o extra pain
1 I can travel anywhere but with extra pain.
2 Pain is bad but I can take journeys over 2 hrs.
3 Pain restricts me to journeys less than 1 hr.
4 Pain restricts me to short journeys under ½ hr.
5 Pain prevents travel, except to my doctor.

Your Signature_____ **Date** _____

Informed Consent Form

Patient Name_____ Date _____

Provider Name: Paul J. Roob, D.C.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including examination, test, various modes of physical therapy and/or diagnostic X-rays, on me (or on the patient named above, for whom I am legally responsible) which are recommended by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future render treatment to me, while employed by, work for, or at, the office, or at any other related office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic and /or with other office or clinic personnel the nature, purpose and any risks of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, paralysis and strains/sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him, is in my best interest.

I have read, or have had read to me, the above explanation of chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

Acknowledgment of Notice of Privacy Practices

I hereby acknowledge that I have received, or been offered a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact Paul J Roob, D.C. at Vermillion Chiropractic Clinic (605-624-9101). I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way.

Patient Signature _____ Date _____