

**Springfield Family
Chiropractic PC**7 E Woodland Ave, Springfield, PA 19064
610-544-6336 fax 610-544-7059**Demographic Information**

Date: / /

Name:

Date of Birth: / /

Phone:

E-mail address (for appt reminders):

Street Address:

City:

State:

Zip:

Insurance InformationIf no insurance, check here: ☐

Insurance Company Name:

Policy ID Number:

If you are not the policy holder, policy holder's name and date of birth:

Medical History

Hospitalizations:

Surgeries:

Prior Accidents/Injuries:

Ongoing Illness:

Allergies:

Current Medications:

Family History:

Previous Tests:

Dietary Habits:

Nutritional Supplements:

Prior Chiropractic Care:

Are you pregnant?

Do you have a pacemaker or defibrillator?

Other Comments (use back of page, if needed):

Date of last x-ray, CT scan, or MRI:

How did you hear about our office?

☐

Family/friend

☐

Internet Search

☐

Other

Springfield Family Chiropractic, P.C.

Dr. Gary S. Miller
7 E. Woodland Avenue
Springfield, PA 19064

Patient Name: _____

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: Medicare does not pay for some care that you may receive in this office.

We expect Medicare may not pay for the the services below.

Service	Reason Medicare May Not Pay	Cost
Initial evaluation	Medicare does not cover an evaluation done in a chiropractic office.	\$80.00
Adjunctive therapies (optional)	Medicare does not cover adjunctive therapies (ultrasound, electro-stim) done in a chiropractic office.	\$20.00
Spinal Manipulation – Wellness	Medicare does not cover spinal manipulations (adjustments) that are not medically necessary, or that are considered “maintenance” care.	\$42.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.

OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the services listed above, but do not bill Medicare. You may ask to be paid now, as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the services listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

Additional Information:

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	J. Date:
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Patient Name _____

Date: ____ / ____ / ____

Symptoms - Primary reason(s) for seeking care:

Location (Circle One):

Head Neck Upper back Mid back Low back
Buttocks Tailbone Jaw Shoulder Elbow
Wrist Hip Knee Ankle Foot Other _____

Type of Symptom (Circle All That Apply):

Aching Pain Dull Pain Sharp Pain Stabbing Pain
Burning Pain Stiff Weak Numb/Tingling
Radiating into: _____

Pain Level: 1 2 3 4 5 6 7 8 9 10

Which side?

Left Right Both

How frequent?

Constant Frequent
Intermittent Occasional

Aggravated by:

Bending Twisting Standing Sitting

Other: _____

Relieved by:

Rest Heat Ice Pain Reliever

Other: _____

Location (Circle One):

Head Neck Upper back Mid back Low back
Buttocks Tailbone Jaw Shoulder Elbow
Wrist Hip Knee Ankle Foot Other _____

Type of Symptom (Circle All That Apply):

Aching Pain Dull Pain Sharp Pain Stabbing Pain
Burning Pain Stiff Weak Numb/Tingling
Radiating into: _____

Pain Level: 1 2 3 4 5 6 7 8 9 10

Which side?

Left Right Both

How frequent?

Constant Frequent
Intermittent Occasional

Aggravated by:

Bending Twisting Standing Sitting

Other: _____

Relieved by:

Rest Heat Ice Pain Reliever

Other: _____

Location (Circle One):

Head Neck Upper back Mid back Low back
Buttocks Tailbone Jaw Shoulder Elbow
Wrist Hip Knee Ankle Foot Other _____

Type of Symptom (Circle All That Apply):

Aching Pain Dull Pain Sharp Pain Stabbing Pain
Burning Pain Stiff Weak Numb/Tingling
Radiating into: _____

Pain Level: 1 2 3 4 5 6 7 8 9 10

Which side?

Left Right Both

How frequent?

Constant Frequent
Intermittent Occasional

Aggravated by:

Bending Twisting Standing Sitting

Other: _____

Relieved by:

Rest Heat Ice Pain Reliever

Other: _____

Location (Circle One):

Head Neck Upper back Mid back Low back
Buttocks Tailbone Jaw Shoulder Elbow
Wrist Hip Knee Ankle Foot Other _____

Type of Symptom (Circle All That Apply):

Aching Pain Dull Pain Sharp Pain Stabbing Pain
Burning Pain Stiff Weak Numb/Tingling
Radiating into: _____

Pain Level: 1 2 3 4 5 6 7 8 9 10

Which side?

Left Right Both

How frequent?

Constant Frequent
Intermittent Occasional

Aggravated by:

Bending Twisting Standing Sitting

Other: _____

Relieved by:

Rest Heat Ice Pain Reliever

Other: _____

Oswestry Low Back Pain Disability Questionnaire

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

SECTION 1: Pain Intensity <ul style="list-style-type: none"><input type="radio"/> I have no pain at the moment.<input type="radio"/> The pain is very mild at the moment.<input type="radio"/> The pain is moderate at the moment.<input type="radio"/> The pain is fairly severe at the moment.<input type="radio"/> The pain is very severe at the moment.<input type="radio"/> The pain is the worst imaginable at the moment.	SECTION 6: Standing <ul style="list-style-type: none"><input type="radio"/> I can stand as long as I want without extra pain.<input type="radio"/> I can stand as long as I want but it gives me extra pain.<input type="radio"/> Pain prevents me from standing more than 1 hour.<input type="radio"/> Pain prevents me from standing for more than 30 minutes.<input type="radio"/> Pain prevents me from standing for more than 10 minutes.<input type="radio"/> Pain prevents me from standing at all.
SECTION 2: Personal Care (e.g. washing, dressing) <ul style="list-style-type: none"><input type="radio"/> I can look after myself normally without causing extra pain.<input type="radio"/> I can look after myself normally but it causes extra pain.<input type="radio"/> It is painful to look after myself and I am slow and careful.<input type="radio"/> I need some help but can manage most of my personal care.<input type="radio"/> I need help every day in most aspects of self-care.<input type="radio"/> I do not get dressed, wash with difficulty and stay in bed.	SECTION 7: Sleeping <ul style="list-style-type: none"><input type="radio"/> My sleep is never disturbed by pain.<input type="radio"/> Because of pain I have less than 6 hours sleep.<input type="radio"/> Because of pain I have less than 4 hours sleep.<input type="radio"/> Because of pain I have less than 2 hours sleep.<input type="radio"/> Pain prevents me from sleeping at all.<input type="radio"/> My sleep is occasionally disturbed by pain.
SECTION 3: Lifting <ul style="list-style-type: none"><input type="radio"/> I can lift heavy weights without extra pain.<input type="radio"/> I can lift heavy weights, but it gives me extra pain.<input type="radio"/> Pain prevents me from lifting heavy weights off the floor I can manage if they are conveniently placed (e.g., on a table.)<input type="radio"/> Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.<input type="radio"/> I can only lift very light weights.<input type="radio"/> I cannot lift or carry anything.	SECTION 8: Sex Life (if applicable) <ul style="list-style-type: none"><input type="radio"/> My sex life is normal and causes no extra pain.<input type="radio"/> My sex life is normal but causes some extra pain.<input type="radio"/> My sex life is nearly normal but is very painful.<input type="radio"/> My sex life is severely restricted by pain.<input type="radio"/> My sex life is nearly absent because of pain.<input type="radio"/> Pain prevents any sex life at all.
SECTION 4: Walking <ul style="list-style-type: none"><input type="radio"/> Pain does not prevent me walking any distance.<input type="radio"/> Pain prevents me from walking more than 1 mile.<input type="radio"/> Pain prevents me from walking more than 1/2 mile.<input type="radio"/> Pain prevents me from walking more than 100 yards.<input type="radio"/> I can only walk using a stick or crutches.<input type="radio"/> I am in bed most of the time.	SECTION 9: Social Life <ul style="list-style-type: none"><input type="radio"/> My social life is normal and gives me no extra pain.<input type="radio"/> My social life is normal but increases the degree of pain.<input type="radio"/> Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sport.<input type="radio"/> Pain has restricted my social life and I do not go out as often.<input type="radio"/> Pain has restricted my social life to my home.<input type="radio"/> I have no social life because of pain.
SECTION 5: Sitting <ul style="list-style-type: none"><input type="radio"/> I can sit in any chair as long as I like.<input type="radio"/> I can only sit in my favorite chair as long as I like.<input type="radio"/> Pain prevents me sitting more than 1 hour.<input type="radio"/> Pain prevents me from sitting more than 30 minutes.<input type="radio"/> Pain prevents me from sitting more than 10 minutes.<input type="radio"/> Pain prevents me from sitting at all.	SECTION 10: Traveling <ul style="list-style-type: none"><input type="radio"/> I can travel anywhere without pain.<input type="radio"/> I can travel anywhere but it gives me extra pain.<input type="radio"/> Pain is bad but I manage journeys over 2 hours.<input type="radio"/> Pain restricts me to journeys of less than 1 hour.<input type="radio"/> Pain restricts me to short necessary journeys under 30 minutes.<input type="radio"/> Pain prevents me from traveling except to receive treatment.

Patient Name:

Date:

Score:

Neck Disability Index

This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only the one box that applies to you.** We realise you may consider the two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem.

<p>SECTION 1: Pain Intensity</p> <ul style="list-style-type: none"> <input type="radio"/> I have no pain at the moment. <input type="radio"/> The pain is mild at the moment. <input type="radio"/> The pain comes and goes and is moderate. <input type="radio"/> The pain is moderate and does not vary much. <input type="radio"/> The pain is very severe, but comes and goes. <input type="radio"/> The pain is severe and does not vary much. 	<p>SECTION 6: Concentration</p> <ul style="list-style-type: none"> <input type="radio"/> I can concentrate fully when I want to with no difficulty. <input type="radio"/> I can concentrate fully when I want to with slight difficulty. <input type="radio"/> I have a fair degree of difficulty in concentrating when I want to. <input type="radio"/> I have a lot of difficulty in concentrating when I want to. <input type="radio"/> I have a great deal of difficulty in concentrating when I want to. <input type="radio"/> I cannot concentrate at all.
<p>SECTION 2: Personal Care (e.g. washing, dressing)</p> <ul style="list-style-type: none"> <input type="radio"/> I can look after myself normally without causing extra pain. <input type="radio"/> I can look after myself normally but it causes extra pain. <input type="radio"/> It is painful to look after myself and I am slow and careful. <input type="radio"/> I need some help but can manage most of my personal care. <input type="radio"/> I need help every day in most aspects of self-care. <input type="radio"/> I do not get dressed, wash with difficulty and stay in bed. 	<p>SECTION 7: Work</p> <ul style="list-style-type: none"> <input type="radio"/> I can do as much work as I want to. <input type="radio"/> I can only do my usual work, but no more. <input type="radio"/> I can do most of my usual work, but no more. <input type="radio"/> I cannot do my usual work. <input type="radio"/> I can hardly do any work at all. <input type="radio"/> I cannot do any work at all.
<p>SECTION 3: Lifting</p> <ul style="list-style-type: none"> <input type="radio"/> I can lift heavy weights without extra pain. <input type="radio"/> I can lift heavy weights, but it gives me extra pain. <input type="radio"/> Pain prevents me from lifting heavy weights off the floor I can manage if they are conveniently placed (e.g., on a table.) <input type="radio"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. <input type="radio"/> I can only lift very light weights. <input type="radio"/> I cannot lift or carry anything. 	<p>SECTION 8: Driving</p> <ul style="list-style-type: none"> <input type="radio"/> I can drive my car without neck pain. <input type="radio"/> I can drive my car as long as I want with slight pain in my neck. <input type="radio"/> I can drive my car as long as I want with moderate pain in my neck. <input type="radio"/> I cannot drive my car as long as I want because of moderate pain in my neck. <input type="radio"/> I can hardly drive my car at all because of severe pain in my neck. <input type="radio"/> I cannot drive my car at all.
<p>SECTION 4: Reading</p> <ul style="list-style-type: none"> <input type="radio"/> I can read as much as I want to with no neck pain. <input type="radio"/> I can read as much as I want with slight neck pain. <input type="radio"/> I can read as much as I want with moderate neck pain. <input type="radio"/> I cannot read as much as I want because of moderate neck pain. <input type="radio"/> I cannot read as much as I want because of severe neck pain. <input type="radio"/> I cannot read at all. 	<p>SECTION 9: Sleeping</p> <ul style="list-style-type: none"> <input type="radio"/> I have no trouble sleeping. <input type="radio"/> My sleep is slightly disturbed (less than 1 hour sleepless). <input type="radio"/> My sleep is mildly disturbed (1-2 hours sleepless). <input type="radio"/> My sleep is moderately disturbed (2-3 hours sleepless). <input type="radio"/> My sleep is greatly disturbed (3-5 hours sleepless). <input type="radio"/> My sleep is completely disturbed (5-7 hours sleepless)
<p>SECTION 5: Headache</p> <ul style="list-style-type: none"> <input type="radio"/> I have no headaches at all. <input type="radio"/> I have slight headaches which come infrequently <input type="radio"/> I have moderate headaches which come infrequently. <input type="radio"/> I have moderate headaches which come frequently. <input type="radio"/> I have severe headaches which come frequently. <input type="radio"/> I have headaches almost all the time. 	<p>SECTION 10: Recreation</p> <ul style="list-style-type: none"> <input type="radio"/> I am able to engage in all recreational activities with no pain in my neck at all. <input type="radio"/> I am able to engage in all recreational activities with some pain in my neck. <input type="radio"/> I am able to engage in most, but not all, recreational activities because of pain in my neck. <input type="radio"/> I am able to engage in a few of my usual recreational activities because of pain in my neck. <input type="radio"/> I can hardly do any recreational activities because of pain in my neck. <input type="radio"/> I cannot do any recreational activities at all.

Patient Name:

Date:

Score:

Springfield Family Chiropractic, P.C.

Dr. Gary S. Miller
7 E. Woodland Avenue
Springfield, PA 19064

Patient Name: _____

Authorization for Assignment and Records Release

I authorize Springfield Family Chiropractic PC to:

1. Release medical records concerning my physical condition to my insurance company, attorney or adjuster in order to process a claim for payment of charges incurred.
2. Be paid directly for their services by my insurance company, attorney, or adjuster.

Payment of Non-Covered Services

In the event that I do not have insurance coverage for services rendered by Springfield Family Chiropractic PC, or my insurance company does not cover all services by Springfield Family Chiropractic PC, I agree to be personally responsible for payment.

Terms of Acceptance

When a patient comes to our office for chiropractic care and we accept a patient for such care, it is essential for both to be working toward the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. Chiropractic has only one goal – to remove vertebral subluxations.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of neural impulses.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation, nor do we offer advice regarding treatment prescribed by others. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will notify you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Privacy Notice

I acknowledge that I have received the *Notice of Privacy Practices*.

By signing below, I indicate that I have read and fully understand the above statements.

Signature: _____

Date: ____/____/____

Springfield Family Chiropractic PC

NOTICE OF PRIVACY PRACTICES

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.

Key Issues

Uses and Disclosures:

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. We may use or disclose identifiable health information about you without your authorization in several situations, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. Your rights: In most cases, you have the right to look at or get a copy of health information about you. If you request copies, we will charge you only normal photocopy fees. You also have the right to receive a list of certain types of disclosures of your information that we made. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.

Our legal duty:

We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and seek your acknowledgement of receipt of this notice. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints:

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact:

Jeanne Miller
7 E. Woodland Ave.
Springfield, PA 19064
610-544-6336

Further Details

1. Uses and Disclosures of Protected Health Information

Following are examples of the types of uses and disclosures of your protected health care information that the provider is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. For example, your protected health information may be provided to a doctor to whom you have been referred to ensure that the doctor has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, in activities related to obtaining payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to your health insurance company or governmental plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support our business activities. For example, when we review employee performance, we may need to look at what an employee has documented in your medical record.

Business Associates: We may share your protected health information with a third party 'business associate' that performs various activities (e.g., billing, transcription services). Whenever an arrangement between us and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Marketing: We may use or disclose certain health information in the course of providing you with information about treatment alternatives, health-related services, or fund-raising. You may contact us to request that these materials not be sent to you.

Written Authorization: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke your authorization, at any time, in writing.

Opportunity to Object: We may use and disclose your protected health information in the following instances. You have the opportunity to object. If you are not present or able to object, then your provider may, using professional judgment, determine whether the disclosure is in your best interest.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care.

Emergencies: In an emergency treatment situation, we will provide you a Notice of Privacy Practices as soon as reasonably practicable after the delivery of treatment.

Communication Barriers: We may use and disclose your protected health information if we have attempted to obtain acknowledgement from you of our Notice of Privacy Practices but have been unable to do so due to substantial communication barriers and we determine, using professional judgment, that you would agree.

Without Opportunity to Object: We may use or disclose your protected health information in the following situations without your authorization or opportunity to object:

Public Health: for public health purposes to a public health authority or to a person who is at risk of contracting or spreading your disease.

Health Oversight: to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

Abuse or Neglect: to an appropriate authority to report child abuse or neglect, if we believe that you have been a victim of abuse, neglect, or domestic violence.

Legal Proceedings: in the course of legal proceedings.

Law Enforcement: for law enforcement purposes, such as pertaining to victims of a crime or to prevent a crime.

Coroners, Funeral Directors, and Organ Donation: for the coroner, medical examiner, or funeral director to perform duties authorized by law and for organ donation purposes.

Research: to researchers when their research has been approved by an Institutional Review Board or Privacy Board.

Soldiers, Inmates, and National Security: to military supervisors of Armed Forces personnel or to custodians of inmates, as necessary. Preserving national security may also necessitate disclosure of protected health information.

Workers' Compensation: to comply with workers' compensation laws.

Compliance: to the Department of Health and Human Services to investigate our compliance. In general, we may use or disclose your protected health information as required by law and limited to the relevant requirements of the law.

2. Your Rights

You have the right to:

- inspect and copy your protected health information.
- request a restriction of your protected health information. You may ask us not to use or disclose certain parts of your protected health information for treatment, payment or healthcare operations. You may also request that information not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request, but if we do agree, then we must act accordingly.
- request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request.
- ask us to amend your protected health information. You may request an amendment of protected health information about you. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and your medical record will note the disputed information.
- receive an accounting of certain disclosures we may have made. This right applies to disclosures for purposes other than treatment, payment or healthcare operations. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures. The right to receive this information is subject to certain exceptions, restrictions and limitations.
- obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.