CRANBERRY CHIROPRACTIC CLINIC

Date First Seen_____

Case No. _____

X-ray No. _____

Self Pay ( )
Insurance ( )
Personal Injury ( )
Workers' Comp ( )
Medicare ( )

PATIENT HISTORY

Patient's Name_____Birth Date_____Sex___Marital Status_____

Address_____Home Phone_____
STREET CITY STATE ZIP

Patient's Occupation/duties_____SocSecNo._____

Employer name & address_____Business Phone_____

_____Cell Phone_____

Name of Spouse or
Parent (if minor)_____Birth Date_____SocSecNo._____

Employer_____Business Phone_____

Address_____

Insurance Company_____Policy#_____

Address_____Claim#_____

ID#_____Medicare #_____
PLEASE SHOW YOUR INSURANCE CARD TO THE RECEPTIONIST

In case of emergency, notify_____Phone_____

Previous chiropractic care (where & when)_____

Has a doctor other than a chiropractor seen you for ANY health condition in the last year? (Yes/No) Explain

_____

Major Complaints (list ALL symptoms)_____

_____

Were these complaints the results of an accident?___If yes, was the accident: (please check)
Auto_____ On The Job_____ At Home_____ Other (please explain)_____

Please describe the accident in full (please use back of form if you need more room)_____

_____

_____

Has the accident or illness resulted in lost work? _____ Last date worked _____ Returned _____

Date injury happened or illness began _____ If chronic, when did symptoms begin recently? _____

Have you ever had a similar condition? _____ If so, when? _____

If you were hurt on the job, have you reported your accident to your employer? _____

To whom? _____ Have you retained an attorney _____ Name and address:

_____

HAVE YOU SUFFERED FROM:

Dizziness	_____	Numbness/Pain/Tingling of arms/hands	_____
Headaches	_____	Numbness/Pain/Tingling of leg/feet	_____
Neck pain/stiffness	_____	Pain between shoulder	_____
Sinus problems	_____	Low back pain/stiffness	_____
Ringing in the ears	_____	Allergies	_____

OTHER (explain)

_____

_____

HISTORY OF ACCIDENTS AND FALLS:

Auto	_____
Severe falls	_____
Broken bones	_____
Knocked unconscious	_____

OTHER (explain)_____

_____

SURGICAL OPERATIONS:_____

MEDICAL HISTORY – HAVE YOU EVER BEEN TOLD YOU HAD:

Anemia	_____	Major infections	_____
Arthritis	_____	Pneumonia	_____
Asthma	_____	Rheumatic fever	_____
Cancer	_____	Rheumatism	_____
Diabetes	_____	Stroke	_____
Heart attack	_____	Tuberculosis	_____
Hypertension	_____	Other	_____

WHEN WERE LAST X-RAYS TAKEN? _____ BY WHOM? _____

ARE YOU ON ANY MEDICATIONS? (please list) _____

IS THERE ANY CHANCE OF PREGNANCY?_____

HOW DID YOU LEARN ABOUT OUR PRACTICE:

Yellow Book	_____	Radio	_____	Referred by	_____
Other Book	_____	TV	_____	Other (please list)	
Newspaper	_____	Internet	_____		_____

Patient Summary Form

PSF-750 (Rev. 7/1/2015)

Instructions
Please complete this form within the specified timeframe. All PSF submissions should be completed online at www.myoptumhealthphysicalhealth.com unless otherwise instructed.

Please review the Plan Summary for more information.

Patient Information

Patient name: Last | First | MI — ○ Female ○ Male — Patient date of birth

Patient address | City | State | Zip code

Patient insurance ID# | Health plan | Group number

Referring physician (if applicable) | Date referral issued (if applicable) | Referral number (if applicable)

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form) | 2. Federal tax ID(TIN) of entity in box #1

3. Name and credentials of the individual performing the service(s) — 1 MD/DO 2 DC 3 PT 4 OT 5 Both PT and OT 6 Home Care 7 ATC 8 MT 9 Other ____

4. Alternate name (if any) of entity in box #1 | 5. NPI of entity in box #1 | 6. Phone number

7. Address of the billing provider or facility indicated in box #1 | 8. City | 9. State | 10. Zip code

Provider Completes This Section:

Date you want *THIS* submission to begin:

Cause of Current Episode
1. Traumatic
2. Unspecified
3. Repetitive
4. Post-surgical →
5. Work related
6. Motor vehicle

Date of Surgery

Type of Surgery
1. ACL Reconstruction
2. Rotator Cuff/Labral Repair
3. Tendon Repair
4. Spinal Fusion
5. Joint Replacement
6. Other ____

Diagnosis (ICD codes)
Please ensure all digits are entered accurately

1° 2° 3° 4°

Patient Type
1. New to your office
2. Est'd, new injury
3. Est'd, new episode
4. Est'd, continuing care

Nature of Condition
1. Initial onset (within last 3 months)
2. Recurrent (multiple episodes of < 3 months)
3. Chronic (continuous duration > 3 months)

DC ONLY
Anticipated CMT Level
○ 98940 ○ 98941 ○ 98942 ○ 98943

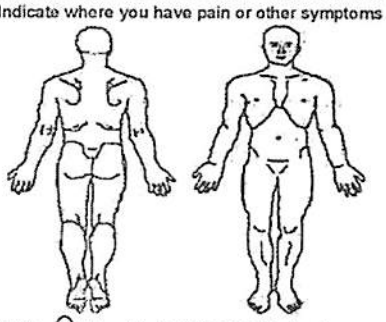
Current Functional Measure Score
Neck Index | DASH | (other FOM)
Back Index | LEFS

Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

Indicate where you have pain or other symptoms



1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:

Last 24 hours: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

Past week: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

4. How often do you experience your symptoms?
(1) Constantly (76%-100% of the time) (2) Frequently (51%-75% of the time) (3) Occasionally (26% - 50% of the time) (4) Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)
(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

6. How is your condition changing, since care began at *this* facility?
(0) N/A — This is the initial visit (1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better

7. In general, would you say your overall health right now is...
(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor

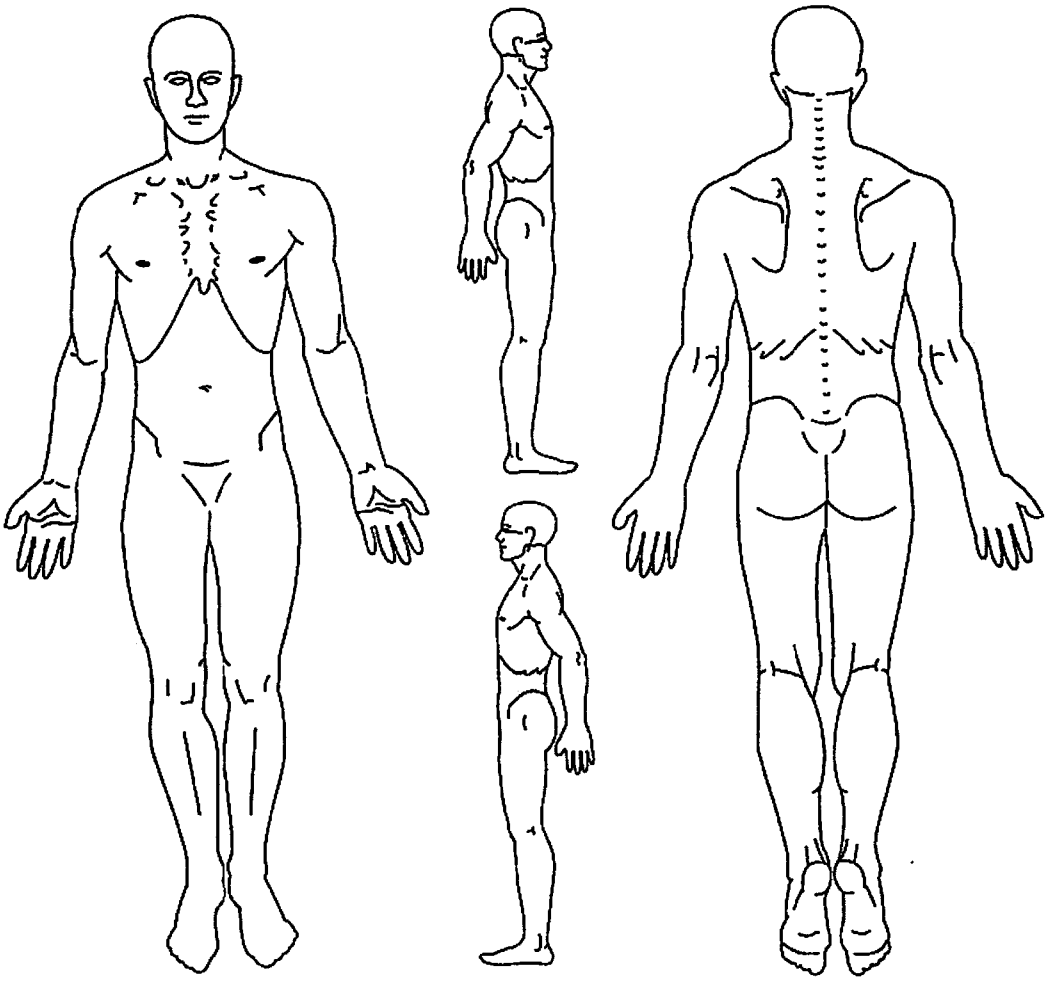
Patient Signature: X _____ **Date:** _____

Patient Name(Print)_____ Date_____

Patient ID #_____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull
B = Burning
N = Numb
S = Stabbing/Cutting
T = Tingling (Pins & Needles)
C = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right **now:**

No Pain — Unbearable Pain

Rate your pain at its **best** in the past week:

No Pain — Unbearable Pain

Rate your **average** pain in the past week:

No Pain — Unbearable Pain

Rate your **worst** pain in the past week:

No Pain — Unbearable Pain

ROLAND MORRIS DISABILITY INDEX

Name _____ **Date** ___/___/___ **File#**_____
(Please Print)

When your back hurts, you may find it difficult to do some of the things you normally do. Check the box before each sentence that describes you today. Leave the box blank if the sentence does not describe you.

- ❑ I stay home most of the time because of my back.
- ❑ I change positions frequently to try and 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 that I usually do around the house.
- ❑ Because of my back, I use a handrail to get upstairs.
- ❑ Because of my back, I lie down to rest more.
- ❑ Because of my back , I have to hold on to something to get out of an easy chair.
- ❑ Because of my back, I try to get other people to do things for me.
- ❑ I get dressed more slowly 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 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.
- ❑ I find it difficult to turn over in bed because of my back.
- ❑ My appetite is not very good because of my back.
- ❑ I have trouble putting on my socks (stockings) because of my back.
- ❑ I only walk short distances because of my back pain.
- ❑ I sleep less well because of my back pain.
- ❑ Because of my back pain, I get dressed with help from someone else.
- ❑ I sit down for most of the day because of my back.
- ❑ I avoid heavy jobs around the house because of my back.
- ❑ Because of my back pain, 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.

Form by Roland M, Morris R. Spine 1983;8(2):141-144. Lippincott-Raven Publishers

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this consent form and a copy of your privacy notice (Notice of Privacy Practices for Protected Health Information).

_____ _____

Printed Name Authorized Provider Representative

_____ _____

Signature Date

_____

Date

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and information and to leave messages on your answering machine or with individuals at your home or place of employment.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____

Patient Name Printed Date

_____ _____

Patient Signature Authorized Provider Representative

_____ _____

Personal Representative Printed Personal Representative Signature

_____

Description of personal representative's authority to act for the patient.

CRANBERRY CHIROPRACTIC CLINIC

DR. JOHN J. HONACKI
20280 RT. 19 – UNIT #2
CRANBERRY TOWNSHIP, PA 16066 – 6125
Phone: (724) 776-5095
Fax: (724) 776-5175

FINANCIAL POLICY

The Cranberry Chiropractic Clinic will submit all claims to the appropriate insurance companies. The following policies apply with regards to your insurance:

1. Any NON-COVERED SERVICES OR ITEMS are your responsibility and should be paid once notified by the office.
2. Any co-payment amounts are DUE when services are rendered.
3. Any deductible amounts are YOUR responsibility.

I acknowledge and I have fully read and understand the above financial policy and agree to abide by these policies.

Signed: _____ Date: _____