

# Welcome

## Patient Information

Date \_\_\_\_\_  
SS/HIC/Patient ID # \_\_\_\_\_  
Patient Name \_\_\_\_\_  
Last Name \_\_\_\_\_  
First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
E-mail \_\_\_\_\_  
Sex  M  F Age \_\_\_\_\_  
Birthdate \_\_\_\_\_  
 Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years  
Occupation \_\_\_\_\_  
Patient Employer/School \_\_\_\_\_  
Employer/School Address \_\_\_\_\_  
Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_  
Spouse's Name \_\_\_\_\_  
Birthdate \_\_\_\_\_  
SS# \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

## Phone Numbers

Home Phone (\_\_\_\_\_) \_\_\_\_\_  
Cell Phone (\_\_\_\_\_) \_\_\_\_\_  
Best time and place to reach you \_\_\_\_\_  
**IN CASE OF EMERGENCY, CONTACT**  
Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Home Phone (\_\_\_\_\_) \_\_\_\_\_  
Work Phone (\_\_\_\_\_) \_\_\_\_\_

## Insurance

Who is responsible for this account? \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Group # \_\_\_\_\_  
Is patient covered by additional insurance?  Yes  No  
Subscriber's Name \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

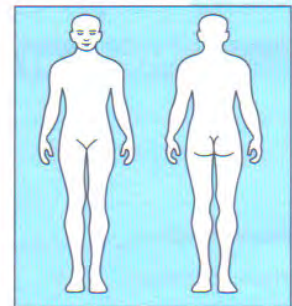
\_\_\_\_\_  
Date Relationship to Patient

## Accident Information

Is condition due to an accident?  Yes  No  
Date \_\_\_\_\_  
Type of accident  Auto  Work  Home  Other  
To whom have you made a report of your accident?  
 Auto Insurance  Employer  Worker Comp.  Other  
Attorney Name (if applicable) \_\_\_\_\_

## Patient Condition

Reason for Visit \_\_\_\_\_  
When did your symptoms appear? \_\_\_\_\_  
Is this condition getting progressively worse?  Yes  No  Unknown  
Mark an X on the picture where you continue to have pain, numbness, or tingling.  
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_  
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other  
How often do you have this pain? \_\_\_\_\_  
Is it constant or does it come and go? \_\_\_\_\_  
Does it interfere with your  Work  Sleep  Daily Routine  Recreation  
Activities or movements that are painful to perform  Sitting  Standing  Walking  Bending  Lying Down





# Health History

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy

Chiropractic Services  None  Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_

Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_

Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraine			Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other _____		
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
Chicken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
			Measles	<input type="checkbox"/> Yes	<input type="checkbox"/> No						

### EXERCISE

- None
- Moderate
- Daily
- Heavy

### WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

### HABITS

- Smoking
- Alcohol
- Coffee/Caffeine Drinks
- High Stress Level

Packs/Day \_\_\_\_\_  
 Drinks/Week \_\_\_\_\_  
 Cups/Day \_\_\_\_\_  
 Reason \_\_\_\_\_

Are you pregnant?  Yes  No Due Date \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

### Medications

### Allergies

### Vitamins/Herbs/Minerals

_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (_____) _____	_____	_____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>
CITY	STATE	7. INSURED'S ADDRESS (No., Street)
ZIP CODE	TELEPHONE (Include Area Code) ( )	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>
a. OTHER INSURED'S POLICY OR GROUP NUMBER	b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	11. INSURED'S POLICY GROUP OR FECA NUMBER
c. EMPLOYER'S NAME OR SCHOOL NAME	d. INSURANCE PLAN NAME OR PROGRAM NAME	a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. <b>SIGNED</b> _____ <b>DATE</b> _____		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <b>If yes, return to and complete item 9 a-d.</b> 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. <b>SIGNED</b> _____
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. _____ 17b. NPI _____	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	23. PRIOR AUTHORIZATION NUMBER
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ _____
29. AMOUNT PAID \$ _____		30. BALANCE DUE \$ _____
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____		32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. _____
33. BILLING PROVIDER INFO & PH # ( )		a. NPI _____ b. _____

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

**BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.**

**NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.**

#### **REFERS TO GOVERNMENT PROGRAMS ONLY**

**MEDICARE AND CHAMPUS PAYMENTS:** A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

#### **BLACK LUNG AND FECA CLAIMS**

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

#### **SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)**

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

**NOTICE:** Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

#### **NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)**

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

**FOR MEDICARE CLAIMS:** See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

**FOR OWCP CLAIMS:** Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

**FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S):** To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

**ROUTINE USE(S):** Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

**DISCLOSURES:** Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

#### **MEDICAID PAYMENTS (PROVIDER CERTIFICATION)**

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

**SIGNATURE OF PHYSICIAN (OR SUPPLIER):** I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

**NOTICE:** This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

OSWESTRY DISABILITY QUESTIONNAIRE

Name: \_\_\_\_\_

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 realize 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**

- 0 I have no pain at the moment.
- 1 The pain is very mild at the moment.
- 2 The pain is moderate at the moment.
- 3 The pain is fairly severe at the moment.
- 4 The pain is very severe at the moment.
- 5 The pain is the worst imaginable at the moment.

**Section 2: Personal Care (washing, dressing, etc.)**

- 0 I can look after myself normally without causing extra pain.
- 1 I can look after myself normally, but it causes extra pain.
- 2 It is painful to look after myself, and I am slow and careful.
- 3 I need some help, but can manage most of my personal care.
- 4 I need help every day in most aspects of self-care.
- 5 I do not get dressed, wash with difficulty, and stay in bed.

**Section 3: Lifting**

- 0 I can lift heavy objects without extra pain.
- 1 I can lift heavy weights, but it causes me extra pain.
- 2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed, e.g., on a table.
- 3 Pain prevents me from lifting heavy weights, but I can manage light to medium weight if they are conveniently placed.
- 4 I can only lift very light weights.
- 5 I cannot lift or carry anything.

**Section 4: Walking\***

- 0 Pain does not prevent me from walking any distance.
- 1 Pain prevents me from walking more than 2km/1.2 miles.
- 2 Pain prevents me from walking more than 1km/0.6 miles.
- 3 Pain prevents me from walking more than 500 metres/0.3 miles.
- 4 I can only walk using a stick or crutches.
- 5 I am in bed most of the time.

**Section 5: 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 more than one hour.
- 3 Pain prevents me from sitting more than 30 minutes.
- 4 Pain prevents me from sitting more than 10 minutes.
- 5 Pain prevents me from sitting at all.

**Section 6: Standing**

- 0 I can stand as long as I want without extra pain.
- 1 I can stand as long as I want, but it gives me extra pain.
- 2 Pain prevents me from standing for more than 1 hour.
- 3 Pain prevents me from standing for more than 30 minutes.
- 4 Pain prevents me from standing for more than 10 minutes.
- 5 Pain prevents me from standing at all.

**Section 7: Sleeping**

- 0 My sleep is never disturbed by pain.
- 1 My sleep is occasionally disturbed by pain.
- 2 Because of pain, I get less than 6 hours of sleep.
- 3 Because of pain, I get less than 4 hours of sleep.
- 4 Because of pain, I get less than 2 hours of sleep.
- 5 Pain prevents me from sleeping at all.

**Section 8: Sex Life (if applicable)**

- 0 My sex life is normal and causes no extra pain.
- 1 My sex life is normal, but causes extra pain.
- 2 My sex life is nearly normal, but is very painful.
- 3 My sex life is severely restricted by pain.
- 4 My sex life is nearly absent because of pain.
- 5 Pain prevents any sex life at all.

**Section 9: Social Life**

- 0 My social life is normal and gives me no extra pain at all.
- 1 My social life is normal, but increases my degree of pain.
- 2 Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., sports).
- 3 Pain has restricted my social life, and I do not go out as often.
- 4 Pain has restricted my social life to my home.
- 5 I have no social life because of pain.

**Section 10: Traveling**

- 0 I can travel anywhere without pain.
- 1 I can travel anywhere, but it gives me extra pain.
- 2 Pain is bad, but I manage trips over 2 hours.
- 3 Pain restricts me to trips of less than 1 hour.
- 4 Pain restricts me to short, necessary trips under 30 minutes.
- 5 Pain prevents me from traveling except to receive treatments.

Index Score = (Sum of all statements selected / (# of sections with a statement selected x 5) x 100

Index Score: \_\_\_\_\_





Thank you for choosing Virginia Family Chiropractic Health Center, P.C., (VFCHC) for your health care needs. We are committed to provide the very best chiropractic care and successful treatment. The following is a statement of our financial policy. For our existing patients', this policy replaces prior financial policies. Our financial policy applies to all services rendered by Dr. Fermin de la Jara, and any other employed doctor and staff of Virginia Family Chiropractic Health Center, P.C.

**PROOF OF IDENTIFICATION:**

Two forms of identification are required. A copy of a valid state issued driver's license is required. Secondary forms of acceptable identification can include health or automobile insurance cards, or a valid credit card. If you are a minor, your legal guardian will need to provide this information for your file.

**PATIENT RESPONSIBILITIES & FINANCIAL POLICIES:**

Demographic Accuracy:

Please provide accurate and complete information about your health history, mailing address, health insurance, and any other applicable billing information. It is the patient's responsibility to inform VFCHC of any changes to include name, marital status, social security number, address, telephone, insurance coverage to include deductible, co-payments, etc. immediately. *Any insurance payment denials or billing errors due to non-updated patient supplied information will result in transfer to patient's responsibility.*

Know Your Coverage, Benefits & Referral Requirements:

- I. Your health insurance is a contract between you and your health insurance plan(s). Patients are responsible for understanding their health insurance coverage(s), benefits, and referral requirements to receive diagnostic and therapeutic services from our practice and doctors. Patients are responsible for securing the necessary written referrals, pre-authorizations, or pre-certifications from your primary care physician or health plan prior to services being rendered with VFCHC. If VFCHC has not received necessary authorizations prior to your appointment, **the appointment may be rescheduled (or) if seen, the patient will be personally responsible for payment of services for that visit.** Any coverage or payment dispute is a matter between the insurance policy holder and their respective insurance company.
- II. VFCHC participates with most major insurance companies. As a courtesy, we file claims with given insurance companies and are directly paid as authorized by the patients' signature on this 'assignment of benefits' below. Co-payments and payment for all vitamins and supplements are due at the date of service. For participating insurance plans, VFCHC will accept payments based on the contracted agreement. For plans of which VFCHC does not participate (i.e., there is no contracted agreement), full payment from the patient will be expected on the same date of service.

Self-Pay Patients:

Patients without health insurance coverage are expected to pay for all services rendered on the same date of services.

Personal Injury (PI), Worker's Compensation (WC) & Motor Vehicle Accidents (MVA):

VFCHC does not bill general health insurance for such treatments – claims are made to the patient's vehicle med pay, personal attorney or workers compensation department/company. The patient is responsible for providing necessary information relating to their specific case type, (i.e., PI, WC or MVA) to include: claim numbers, claims representative contact numbers, attorney information (when applicable),

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Virginia Family Chiropractic Health Center, P.C.

date of accident, etc. due to the nature of such cases, VFCHC understands that payment/settlement in such cases may take time. However, if any PI, WC or MVA has not begun payment for services within 12 months of the last date of treatment, payment responsibility will shift to the patient. Under such circumstances, a monthly payment plan may be set up through our billing department. \*Vitamins, support pillows or any other supplements are not billed through PI, WC or MVA and will be the patient's responsibility.

Patient Payment Agreement:

- I. I understand that I am financially responsible for all charges regardless of third-party involvement. I agree to pay any deductible, coinsurance, co-payment, or services deemed as 'non-covered' by insurance carriers. If insurance has not paid on an account within 75 days, the outstanding balance will become the patient's responsibility. Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, non-payment at time of service, or any other reason not listed here within, I agree to pay all charges within 45 days. Failure to pay outstanding balances in full (or establish a written payment plan) will be considered delinquent. Delinquent account balances will be subject to legal action consisting of: assignment to a collection agency or an attorney. The patient will assume responsibility for any collection or attorney fees and authorizes release of any demographic information (i.e., name, address, telephone number, SSN, etc.) to any attorney or collection agency if the above financial terms are breached.
- II. I agree to pay a \$25.00 returned check fee for each payment that is returned by the bank. I agree to pay a \$10.00 fee for each missed appointment not cancelled at least 24 hours in advance. I understand that any requests for copies of my chiropractic records must be in writing. VFCHC does not fax records and requires a minimum of 24 hours to prepare copies of any records or x-rays. The completion of special forms or reports has a minimum charge of \$25.00 for each form; please contact VFCHC with any requests and fee charges for specific reports.

Authorization And Assignment Of Insurance Benefits:

I permit a copy of this authorization and signature to be used in place of this original for manual, electronic, or telephone transmission. I authorize VFCHC to apply for benefits for services rendered to myself or a minor child/dependant under any health insurance policies providing benefits from my insurance company to VFCHC (including benefits payable under Title XVIII of the Social security Act.) I irrevocably authorize all such payments to VFCHC. I authorize VFCHC to contact my employer or my insurance company for insurance verification and/or coverage of benefits.

**In consideration for chiropractic service rendered I acknowledge notice of the financial policy below and agree to pay for said chiropractic services according to the above terms. My signature below indicates that I have read and agree to the above policy.**

\_\_\_\_\_  
Patient/Guardian/Responsible Party/Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Guardian/Responsible Party/Printed Name

\_\_\_\_\_  
Date

## Consent for Release and Use of Confidential Information And Acknowledgement of Notice of Privacy Practices

I, \_\_\_\_\_, hereby  
(Name of Patient or Authorized Agent)

give my consent to VA Family Chiropractic Health Center, PC to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of: \_\_\_\_\_.

I acknowledge the review and/or receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand the physician has reserved the right to change his/her privacy practices that are described in the Notice. I also understand that a copy of any revised notice will be available to me upon written request to the Privacy Officer.

I understand that this consent is valid until it is revoked by me. I understand that I make revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

I understand that I have the right to request that the practice restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or health operations. I understand the practice and their agents must adhere to such restrictions.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

If you are NOT the patient, please specify your relationship to the patient: \_\_\_\_\_

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