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? _____

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

Phone Numbers

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

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) _____

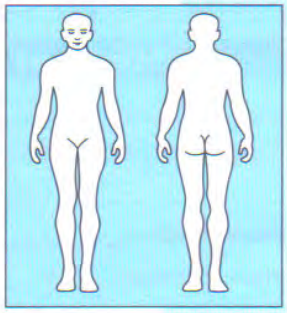
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

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

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking — Packs/Day _____
☐ Alcohol — Drinks/Week _____
☐ Coffee/Caffeine Drinks — Cups/Day _____
☐ High Stress Level — 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 (____) _____		

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (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 ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ 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. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

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.

VIRGINIA FAMILY CHIROPRACTIC HEALTH CENTER

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: _____

Virginia Family Chiropractic Health Center, P.C.

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 heath 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),

12546 Dillingham Square, Suite 102
Lake Ridge, VA 22192
(703) 730-1600
(703) 590-1260 fax

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

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VIRGINIA FAMILY CHIROPRACTIC HEALTH CENTER

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: _____

Virginia Family Chiropractic
Health Center, PC
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