O'LEARY CHIROPRACTIC, P.L.L.C.

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# Patient Demographics

Date:_____

Name:_____

SS#:_____

DOB:_____ Age:_____

Address:_____ City, State, Zip:_____

Best Phone number to reach you:_____ Cell / Home / Work (circle one)

Email Address:_____

Status: Minor / Single / Married (circle one) Other:_____

Who is your medical doctor?_____ Referred to our office by?_____

**Emergency Contact**

Name:_____ Relation:_____ Phone:_____

**Employment Information**

Employer Name:_____ Address:_____ Phone:_____

**Primary Insurance**

Insurance Company_____

Subscriber ID:_____ Insured's Name:_____

Insured's SS#:_____ Relation:_____ DOB:_____

# Medical History

Name:_____

1. Reason for today's visit: Emergency / New injury / Old injury / Chronic pain (circle one).

2. Rate your pain: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain ever (circle one).

3. How often is pain present: 0-25% 25-50% 50-75% 75-100% of the time (circle one).

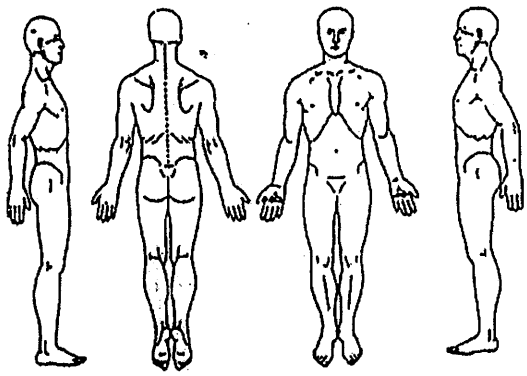
4. How did your pain start?_____

5. When and where did it start?:_____

6. What activities does your condition interfere with?_____

7. Have you had similar pains in the past? Yes / No Explain:_____

8. Please circle the affected area(s).



9. Please list **ALL** surgeries and procedures:_____

_____

10. Please list **ALL** medical and health problems:_____

_____

11. Do you have implanted devices in your body? (Pacemaker, Cardiac monitor, etc):_____

_____

12. Family Health History:_____

13. Do you smoke? Y / N How much?_____ Do you take vitamin/supplements? Y / N

14. **Women Only**: Are you pregnant? Y/ N How many weeks?___ Are you Nursing? Y / N

•Our policy requires paying in full for all services rendered at the time of your visit, unless other arrangements have been made with the business manager. If the account is not paid within 90 days of the date of service and no financial arrangements been made, you will be responsible for legal fees, interest fees and any other expense incurred in collecting on your account.

Signature:_____ Date:_____

## ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Financial Responsibility
I have requested professional services from O'Leary Chiropractic ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits
I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information
I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization
I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

O'Leary Chiropractic, PLLC, is a HIPAA compliant office with regards to all personal health information (PHI). A HIPAA Privacy Policy informational packet is available to all patients. I have chosen to **Accept/Decline** this packet.

Date: _____ Name: _____

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# Electronic Health Records Intake Form

*In compliance with requirements for the government EHR incentive program*

**First Name:**_____ **Last Name:**_____

**Email address:** _____@_____ Best Contact #:_____

**Preferred method of communication for patient reminders** (Circle one): Email / Phone / Mail

**DOB:** __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

**Smoking Status (Circle one):** Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

*CMS requires providers to report both race and ethnicity*

**Race (Circle one):** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

**Ethnicity (Circle one):** Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

**Are you currently taking any medications?** (Please include regularly used over the counter medications)

| Medication Name | Dosage and Frequency (i.e. 5mg once a day, etc.) |
|---|---|
| | |
| | |
| | |

**Do you have any medication allergies?**

| Medication Name | Reaction | Onset Date | Additional Comments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

***For office use only***

Height: _____ Weight:_____ Blood Pressure:_____/_____

## BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

**Instructions:** The following scales have been designed to find out about your pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
**Examiner**

**OTHER COMMENTS:** _____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25(3): 141-148.