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

MICHAEL J. O'LEARY, D.C., C.C.S.P.
BRYAN M. STEELE, D.C.
KEVIN B. COLLINS, D.C.

395 Bay Road
Queensbury, NY 12804
Telephone: (518) 793-1205

O'Leary Chiropractic – Intake Form

Confidential Patient Information

Personal Information

Full Name:

Date of Birth: _____ / _____ / _____ Social Security #: _____

Phone Number: _____

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

How did you hear about our office? _____

Insurance Information (*skip if insurance card has been scanned in*)

Insurance Company: _____

Insurance ID #: _____

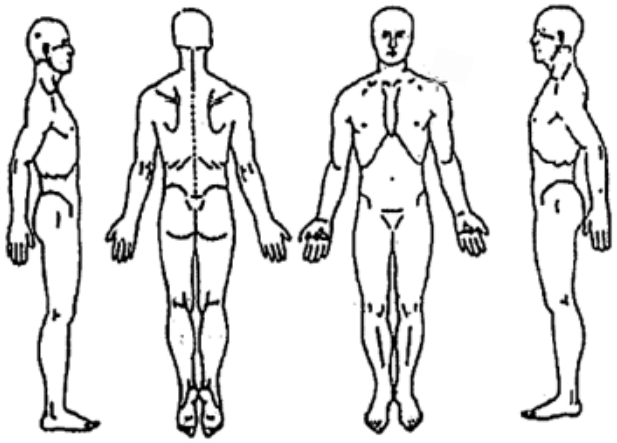
Primary Complaint

When did you pain start or worsen? _____ / _____ / _____

Location of Pain(s): _____

(mark with X or O

where pain is located)



Continue on next page…

Brief description of how pain(s) started: _____

_____

How often is the pain present? (0-100% of the time): _____

What is your average pain level 0-10 (0 is no pain and 10 is the worst possible): _____

Do you have other symptoms associated with your primary complaint?

☐ Headaches ☐ Dizziness ☐ Nausea ☐ Numbness/Tingling ☐ Sleeping Problems

☐ Anxiety ☐ Other: _____

Have you seen other providers for this condition?

☐ Yes ☐ No

If yes, who did you see and where? _____

Date of Visit: _____ / _____ / _____

Were any tests or imaging done? ☐ Yes ☐ No

If yes, please list what was done and where: _____

Medical History

Have you had any surgeries? ☐ Yes ☐ No

If yes, please list: _____

Current medical or health conditions (past or present): _____

_____

Medications you are currently taking (including over-the-counter): _____

_____

If applicable, are you pregnant? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No

Patient 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: _____

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

MICHAEL J. O'LEARY, D.C., C.C.S.P.
BRYAN M. STEELE, D.C.
KEVIN B. COLLINS D.C.

395 Bay Road
Queensbury, NY 12804
Telephone: (518) 793-1205

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.

O'Leary
Chiropractic, PLLC

Michael J. O'Leary, D.C.
Bryan M. Steele, D.C.
Kevin B. Collins, D.C.

395 Bay Road
Queensbury, NY, 12804

TEL 518 793 1205 FAX 518 793 1515

INFORMED CONSENT

Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. At O'Leary Chiropractic, we take the appropriate measures including but not limited to: a detailed history, examination and imaging when warranted in order to prevent and or minimize said risks. While Chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed in consenting to treatment.

Specific Risk Possibilities Associated with Chiropractic Care are:

Stroke: The latest study to investigate whether a unique association between chiropractic manipulation and risk of cervical artery dissection/stroke exists, has yielded similar findings to past investigations; the authors and researchers note "no excess risk of carotid artery stroke after chiropractic care" and no significant risk difference between patients receiving care from a chiropractor or a primary medical provider. The risk of vertebrobasilar stroke (VBA) associated with a visit to a chiropractor's office was shown to be no different from the risk of stroke following a visit to an MD's office. It is likely that the patients in the early stages of VBA stroke are presenting to both the chiropractors and family doctors because of neck pain and headache due to pre-existing vertebral artery dissection which is a risk factor for VBA stroke. At O'Leary Chiropractic, a thorough history, examination, and screening techniques are performed prior to treatment in order to prevent and/or minimize said risk.

Cassidy JD, Boyle E, Cote P, Et al. Risk of carotid stroke after chiropractic care; a population based case - crossover study. J Stroke Cerebrovasc. Dis, 2016 Nov 21.

Soreness: Chiropractic adjustments are sometimes accompanied with post-treatment soreness which relates to the stretching and moving of tight tissue. This is normal and should only last 24-48 hours. Please advise your Doctor of Chiropractic of the soreness.

Disc Herniation or Prolapse: Gentle chiropractic treatment and related techniques have been found to be beneficial in the treatment of spinal disc herniations. However, spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen. A thorough history and examination are performed prior and throughout treatment in order to prevent and/or minimize said risk.

Rib Injury: Manual adjustments to the thoracic spine, in rare cases, may cause a rib injury or fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition such as osteopenia or osteoporosis. Treatment is performed with caution to minimize such risk.

Chiropractic is a system of health care delivery and, therefore, as with any healthcare delivery system, we cannot promise a cure for any symptoms, conditions or disease. An attempt to provide the best Chiropractic care is our goal, and if results are delayed or unsuccessful, we will refer you for testing, imaging and/or to the appropriate healthcare provider(s). If you have any questions, please consult your Doctor of Chiropractic at O'Leary Chiropractic.

Having carefully read the above, I hereby give my informed consent to have Chiropractic treatment administered.

Patient Printed Name: _____ Patient Signature: _____

Parent/Guardian Signature (if Minor): _____ Today's Date: _____