Rolling Valley Chiropractic Centre

Admissions Information: Intake Form

Please Print Clearly

Name: _____ Social Security # (Patient ID): ____-___-_____
Address: _____ Home Phone: _____
City: _____ State: _____ Zip: _____ Cell Phone: _____
Date of Birthday (mm/dd/yyyy): _____ Age: _____ Sex: **M** **F**
E-mail address: _____
E-mail appointment reminders? **Y** **N**
Employer Name: _____ Phone: _____
Employer Address: _____
Spouse/Guardian: _____ (N/A) Phone: _____

Insurance Information:
Insurance Co. Name: _____
Insured's Name: _____ Insured's Date of Birth: _____
ID #: _____ Group #: _____
Patient's Relationship to Insured (circle one): **Self** **Spouse** **Child** **Other**

Primary Care Physician: _____ Phone: _____
Emergency Contact: _____ Relationship to Patient: _____
Emergency Contact Phone: _____

Patient Payment:
I will be paying today by (circle one): **Cash** **Check** **Credit/Debit Card**

Office Policy, Patient Agreement, And Request/Consent for Treatment with Rolling Valley Chiropractic Centre, P.C.

I hereby request and consent to treatment for my presenting complaints. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. It is understood that payment is due at the time that services are rendered. In special instances, RVCC may accept assignment of insurance benefits as portion of the balance due. However, I clearly understand and agree that all services are rendered me are charged directly to me and that I am personally responsible for payment. Returned checks and balances older than 30 days will be subject to additional collection fees. Accounts that require collection services will be assessed a 25% attorney fee. Charges may be made for missed appointment with 24-hour notice.

I certify that all intake information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature: _____ Date: _____
(Parent/Guardian if minor)

Witness (office personnel only): _____

Rolling Valley Chiropractic Centre
9279 Old Keene Mill Road, Burke, VA 22015

Office Policy:
Assignment of Insurance Benefits

We offer the option of insurance assignment, on a select basis, strictly as a courtesy to our patients. As such, our patients must understand that out relationship is with you and not the insurance carrier. You must supply RVCC with all appropriate insurance information to process claims. Regardless of insurance status, **you are responsible for full payment for any and all services rendered to you; any un-met deductibles or fees not paid by your carrier; and for your co-pay (the part of the bill not paid by the insurance carrier).** Your co-pay must be paid at the time of service. If your carrier had not paid a claim within 60 days of submission you are responsible to take an active part in the recovery of that claim. After 90 days, RVCC reserves the right to rescind its assignment. At that time, you will be asked to pay the balance of your bill in full.

PATIENT'S ASSIGNMENT OF INSURANCE PAYMENT BENEFITS

For the treatment provided to me, I hereby authorize the obligated insurance company to pay by check, made-out and mailed directly to:

Rolling Valley Chiropractic Centre
9279 Old Keene Mill Road
Burke, VA 22105
Tax I.D. # 54-1306944

for the benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the charges for professional services rendered. (If my current policy prohibits direct payment to the doctor, then I hereby authorize you to make the check to me and mail it directly to the Rolling Valley Chiropractic Centre address listed above).

I agree to pay, in a currently and timely manner, any balance of charges over and above this insurance payment.

This is a direct assignment of my rights and benefits under this policy and includes all rights to collect payment directly from my insurance company. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjustor, or attorney involved in this case.

I have read, understood and agree to the above condition of assignment of benefits.

Date _____

Signature of Policy Holder _____

Signature of Claimant (Patient) _____

Office Personnel Signature _____

Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

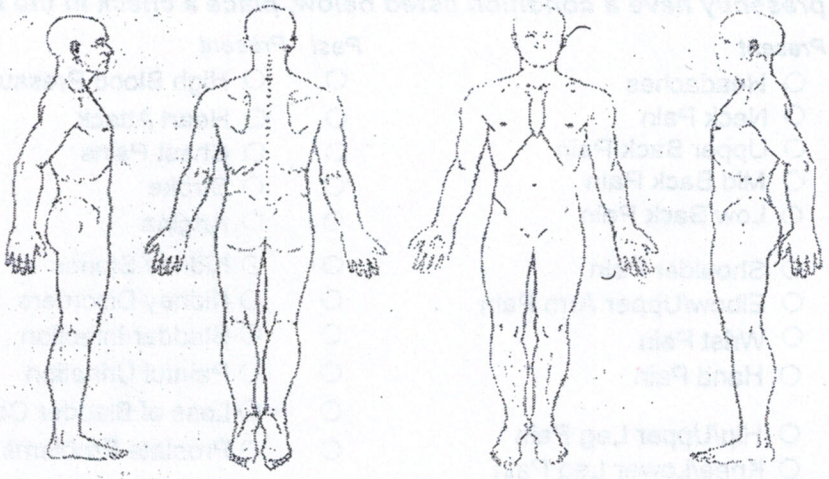
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the <u>past 4 weeks:</u>

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

b. How much has pain interfered with your normal work (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. During the <u>past 4 weeks</u> how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ **Date** _____

Patient Health Questionnaire - page 2

American Chiropractic Network

ACN Use Only rev 4/23/99

Patient Name _____ **Date** _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] (Feet / Inches) Weight [ ][ ][ ] lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
○	○	Headaches	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Frequent Urination
○	○	Mid Back Pain	○	○	Stroke			
○	○	Low Back Pain	○	○	Angina	○	○	Smoking/Use Tobacco Produ
						○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Stones			
○	○	Elbow/Upper Arm Pain	○	○	Kidney Disorders	○	○	Allergies
○	○	Wrist Pain	○	○	Bladder Infection	○	○	Depression
○	○	Hand Pain	○	○	Painful Urination	○	○	Systemic Lupus
			○	○	Loss of Bladder Control	○	○	Epilepsy
○	○	Hip/Upper Leg Pain	○	○	Prostate Problems	○	○	Dermatitis/Eczema/Rash
○	○	Knee/Lower Leg Pain				○	○	HIV/AIDS
○	○	Ankle/Foot Pain	○	○	Abnormal Weight Gain/Loss			
			○	○	Loss of Appetite	***Females Only***		
○	○	Jaw Pain	○	○	Abdominal Pain	○	○	Birth Control Pills
○	○	Joint Swelling/Stiffness	○	○	Ulcer	○	○	Hormonal Replacement
○	○	Arthritis	○	○	Hepatitis	○	○	Pregnancy
○	○	Rheumatoid Arthritis	○	○	Liver/Gall Bladder Disorder	○	○	
○	○	General Fatigue	○	○	Cancer	***Other Health Problems/Issues***		
○	○	Muscular Incoordination	○	○	Tumor	○	○	
○	○	Visual Disturbances	○	○	Asthma	○	○	
○	○	Dizziness	○	○	Chronic Sinusitis	○	○	

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ **Date** _____

Doctor's Additional Comments

_____

_____