

Unity Chiropractic, P.C.

Dr. Tricia A. Shaar, D.C., D.A.C.N.B.

PRE-EXISTING ADULT PATIENT INFORMATION

PRINTED NAME _____ DATE _____
(Last) (First) (M.I.)
ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME # _____ CELL # _____ WORK # _____
DATE OF BIRTH _____ AGE _____ SOCIAL SECURITY # _____
Male Female Single Married Divorced Widowed NAME OF SPOUSE _____
NAMES OF CHILDREN _____
NAME OF EMPLOYMENT _____
OCCUPATION _____ DRIVERS LICENSE # _____
HOW DID YOU HEAR OF DR. SHAAR? _____

EMERGENCY INFORMATION

NAME _____ RELATIONSHIP _____
HOME # _____ CELL # _____ WORK # _____

PAYMENT OPTIONS:

****PLEASE fill-in ALL the CURRENT billing choices for your case below****

1) Billing Information

(Please list information of responsible party, if different from above.)

PRINTED NAME _____
(Last) (First) (M.I.)
ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PHONE _____ WORK PHONE _____
RELATIONSHIP TO INSURED: (please circle one) SELF SPOUSE CHILD OTHER _____
PAYMENT OPTIONS: CASH PERSONAL CHECK VISA MASTER CARD

2) Major Medical Insurance Information (if necessary)

(* Please provide your insurance card when you arrive at the office ***)**

PRIMARY POLICY HOLDER (Name of insured) _____
INSURED'S DATE OF BIRTH: _____ INSURED'S SS#: _____
INSURED'S EMPLOYER: _____
POLICY ID#: _____ GROUP #: _____
INSURANCE COMPANY: _____ INS PROVIDER PHONE #: _____

NAME _____ DATE _____

CHIEF COMPLAINT

1st) Please describe your WORST/Major/Present complaint (another section for another complaint to follow):

Result of Auto Accident: _____ **On the Job Accident:** _____ **Date of Accident:** _____

Have you ever experienced this complaint before? _____

When: _____

Where: _____

How: _____

Why: _____

What Caused It: _____

What Type of Treatment Received: _____

Diagnosis: _____

When did this current complaint start?

Has it become better, worse, or changed in any way since it started?

Describe what makes it better:

Describe what makes it worse:

How would you describe the complaint? (mild, moderate, severe, extreme, painful, numb, stiff, achy, burning, sharp, dull, shooting, discomfort, tight, spasms, etc.)

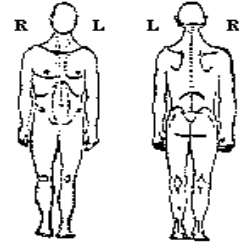
Does it radiate spreading into other areas? (Please describe where.)

Do you have any numbness, tingling, burning, dizziness, nausea, headaches, memory loss, mood changes?

Have you ever sought chiropractic health care before? (Dr.'s name, city or state, length of care, conditions treated, x-rays taken, etc.)

NAME _____ DATE _____

Please indicate on the diagrams below where your area of chief complaint is:



Is it worse:

_____ In the morning

_____ In the mid-day

_____ In the evening

_____ Following:

_____ Routine activity

_____ Moderate activity

Does it interfere with:

_____ Work _____ Days missed

_____ Sleep

_____ Personal activities (describe) _____

_____ Activities of daily living (describe) _____

_____ Other (describe) _____

How frequent it? (i.e. daily, twice daily, three times weekly, occasional, intermittent, frequent, constant, etc.)

Please rate the intensity at its WORST on the scale below:

0 _____ 10
(absent) (extreme)

Please rate the intensity RIGHT NOW on the scale below:

0 _____ 10
(absent) (extreme)

How long does it last? (i.e. # of seconds, # of minutes, # of hours, all day, # of continuous days, etc.)

ANY CHANGES OR ADDITIONS TO YOUR PAST HEALTH HISTORY

Prior conditions requiring surgeries/operations/hospitalizations/pacemaker (include year):

Prior fractures/broken bones/sprained ankles (bone(s) and year): _____

Serious Adult diseases (Crohn's dx, lupus) or Childhood diseases or Health conditions: _____

Automobile or motorcycle injuries (injury and year): _____

Anomalies (explain/describe): _____

Significant falls/accidents/closed head trauma/concussions (injury and year): _____

NAME _____ DATE _____

Present health problems/pregnant (currently under treatment): _____

Vitamins/Supplements (indicate purpose/condition): _____

All Current Medications (indicate purpose/condition/self-medicated/prescribed): _____

ANY CHANGES OR ADDITIONS TO YOUR FAMILY HEALTH HISTORY

Please indicate **WHO** and **WHEN** in your family has or had the following conditions:

Arthritis or Bone Conditions (dx/type): _____

Blood Pressure (high or low): _____

Cancer/Tumors (location): _____

Diabetes (type or age or onset): _____

Epilepsy (type): _____

Strokes (specify): _____

Genetic Problems (specify): _____

Heart or Vascular Conditions (specify): _____

Headaches (i.e. migraines, cluster, etc.): _____

Lung Conditions (specify): _____

Alcoholism/Drug Dependency: _____

Other (specify): _____

Patient Instructions: Please document any changes to your health since your last visit to Unity Chiropractic or over the past 5 years.

| | | | | |
|----|---------|---|--|---|
| 1. | General | <input type="checkbox"/> Fever <input type="checkbox"/> Weight Loss or Gain <input type="checkbox"/> Sweats <input type="checkbox"/> Low Grade Fever | <input type="checkbox"/> Chills <input type="checkbox"/> Fatigue <input type="checkbox"/> Allergies <input type="checkbox"/> Frequent Illness | <input type="checkbox"/> Sleep Disturbances <input type="checkbox"/> Water Intake: _____ <input type="checkbox"/> Nausea <input type="checkbox"/> Normal |
|----|---------|---|--|---|

Patient: _____

Date: _____

| | | | | |
|-----|-------------------|---|---|---|
| 2. | Head | <input type="checkbox"/> Headache/Migraines <input type="checkbox"/> Trauma <input type="checkbox"/> Convulsions | <input type="checkbox"/> Dizziness <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Fainting | <input type="checkbox"/> Pain/Discomfort <input type="checkbox"/> Lightheadedness <input type="checkbox"/> Normal |
| 3. | Eyes | <input type="checkbox"/> Contacts and/or Glasses <input type="checkbox"/> Color Blindness <input type="checkbox"/> Cataracts <input type="checkbox"/> Double Vision <input type="checkbox"/> Poor Night Vision <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Blurry Vision <input type="checkbox"/> Flashes in Front of Eyes <input type="checkbox"/> Spots in Front of Eyes <input type="checkbox"/> Eye Dryness <input type="checkbox"/> Difficulty Reading <input type="checkbox"/> Eye Strain and/or Fatigue | <input type="checkbox"/> Tearing <input type="checkbox"/> Sensitive to Lights <input type="checkbox"/> Crossed Eyes <input type="checkbox"/> Eye Pain <input type="checkbox"/> Eye Twitching <input type="checkbox"/> Normal |
| 4. | Ears | <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Frequent/History Infections <input type="checkbox"/> Itching/Irritation | <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Drainage <input type="checkbox"/> Loud Noise Sensitivity | <input type="checkbox"/> Pain/Earache <input type="checkbox"/> Ringing <input type="checkbox"/> Normal |
| | Nose | <input type="checkbox"/> Post-Nasal Drip <input type="checkbox"/> Sinus Infections <input type="checkbox"/> Changes in Smell | <input type="checkbox"/> Dryness <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Congestion Sidedness | <input type="checkbox"/> Anomaly <input type="checkbox"/> Nasal Obstructions <input type="checkbox"/> Normal |
| 6. | Mouth/ Throat | <input type="checkbox"/> Gum Bleeds <input type="checkbox"/> Dentures <input type="checkbox"/> Changes in Taste <input type="checkbox"/> Speech Problems <input type="checkbox"/> Bite/Chewing Changes <input type="checkbox"/> Dryness | <input type="checkbox"/> Cold Sores and/or Canker Sores <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Sore Throat/Sidedness <input type="checkbox"/> Dental Changes <input type="checkbox"/> Dental Decay <input type="checkbox"/> Metal Taste in Mouth | <input type="checkbox"/> Jaw Pain / TMJ Problems <input type="checkbox"/> Gagging <input type="checkbox"/> Tongue Tied <input type="checkbox"/> Hoarseness <input type="checkbox"/> Gum Troubles <input type="checkbox"/> Normal |
| 7. | Neck | <input type="checkbox"/> Masses <input type="checkbox"/> Swelling <input type="checkbox"/> Enlarged Glands <input type="checkbox"/> Muscle Spasm | <input type="checkbox"/> Stiffness <input type="checkbox"/> Swollen Glands <input type="checkbox"/> Enlarged Thyroid <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Pain <input type="checkbox"/> Range of Motion Changes <input type="checkbox"/> Skin/Temperature Changes <input type="checkbox"/> Normal |
| 8. | Lungs | <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Inhalation Pain <input type="checkbox"/> Exhalation Pain | <input type="checkbox"/> Pneumonia <input type="checkbox"/> Coughing Up Sputum <input type="checkbox"/> Coughing Up Blood <input type="checkbox"/> Lightheadedness <input type="checkbox"/> Difficulty Breathing Lying Down | <input type="checkbox"/> Wheezing <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Chest Pain/Chest Tightness <input type="checkbox"/> Normal |
| 9. | Vascular | <input type="checkbox"/> Pain Over Heart <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Slow/Fast Heart Beats <input type="checkbox"/> Arm/Leg Ache/Heaviness | <input type="checkbox"/> Swelling in Hands/Legs <input type="checkbox"/> Leg Cramps <input type="checkbox"/> Calf Pain <input type="checkbox"/> Toe Temperature Changes <input type="checkbox"/> Finger Temperature Changes <input type="checkbox"/> Vascular Injuries | <input type="checkbox"/> Skin Color Change Legs/Feet/Hand <input type="checkbox"/> Ankle Swelling <input type="checkbox"/> Varicose Veins/Spider Veins <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Nail Bed Changes <input type="checkbox"/> Normal |
| 10. | Gastro-Intestinal | <input type="checkbox"/> Blood in Stool <input type="checkbox"/> Diarrhea/Constipation <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> Bowel Movement <input type="checkbox"/> Distension of Abdomen <input type="checkbox"/> Falling/Dropped Bladders | <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Vomiting of Blood <input type="checkbox"/> Difficult Digestion/Food Sensitivities <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Poor Appetite <input type="checkbox"/> Dropping Reproductive System | <input type="checkbox"/> Heartburn <input type="checkbox"/> Gas or Belching <input type="checkbox"/> Hemorrhoid <input type="checkbox"/> Indigestion <input type="checkbox"/> Liver/Gallbladder History <input type="checkbox"/> Normal |
| 11. | Genito-Urinary | Sexual Dysfunction/Problems Prostate Problems Pus in Urine Bed-Wetting Color: Dark Light Clear | <input type="checkbox"/> Increased Urination <input type="checkbox"/> Decreased Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Incontinence <input type="checkbox"/> Kidney Infections | <input type="checkbox"/> Foul odor of Urine <input type="checkbox"/> Difficulty with Urination <input type="checkbox"/> Urinary Tract Infections (UTI) <input type="checkbox"/> Pain with Urination <input type="checkbox"/> Normal |
| 12. | Skin | <input type="checkbox"/> Rash <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Hair loss <input type="checkbox"/> Dryness <input type="checkbox"/> Eczema <input type="checkbox"/> Body Odors | <input type="checkbox"/> Warts <input type="checkbox"/> Brittle Nails <input type="checkbox"/> Changes in Moles <input type="checkbox"/> Temperature/Pain Changes <input type="checkbox"/> Fever Blisters/Herpes Lesions <input type="checkbox"/> Pimples/Acne | <input type="checkbox"/> Itching <input type="checkbox"/> Healing Time <input type="checkbox"/> Boils <input type="checkbox"/> Hives <input type="checkbox"/> Ulcers <input type="checkbox"/> Normal |
| 13. | Neurology | <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Strokes <input type="checkbox"/> Tremors <input type="checkbox"/> Running into Things <input type="checkbox"/> Muscle Twitches | <input type="checkbox"/> Tingling Sensation <input type="checkbox"/> Numbness Sensation <input type="checkbox"/> Burning Sensation <input type="checkbox"/> Tripping Over Feet <input type="checkbox"/> Balance Problems | <input type="checkbox"/> Weakness <input type="checkbox"/> Difficulty Walking <input type="checkbox"/> Fainting <input type="checkbox"/> Spinning/Dizziness <input type="checkbox"/> Normal |
| 14. | Musculo-Skeletal | Joint Pain/Swelling Stiffness Joint Popping/Moving Bursitis Sciatica: To Knee Past Knee | <input type="checkbox"/> Arthritis/Gout <input type="checkbox"/> Anomaly/Deformities <input type="checkbox"/> Bone Pain <input type="checkbox"/> Bone Disease <input type="checkbox"/> Muscle Spasm/Cramp/Weakness/Achy | <input type="checkbox"/> Fractures <input type="checkbox"/> Dislocations <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Muscle Infection/Disease <input type="checkbox"/> Normal |
| 15. | Psychiatric | Depression Concentration Stress Memory: Short Long | <input type="checkbox"/> Mood Swings <input type="checkbox"/> Nervousness <input type="checkbox"/> Personality Changes <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Anxiety <input type="checkbox"/> Phobias <input type="checkbox"/> Aggressive Behavior/Tendencies <input type="checkbox"/> Normal |

Patient: _____

Date: _____

| | | | | |
|-----|-----------------------|--|--|---|
| 16. | Social History | <input type="checkbox"/> Consume Alcohol <input type="checkbox"/> Smoker Past or Present <input type="checkbox"/> Stress Management <input type="checkbox"/> Social Drugs | <input type="checkbox"/> Exercise Regularly <input type="checkbox"/> Consume Coffee <input type="checkbox"/> Stress Level 1- 10: <input type="checkbox"/> Hobbies | <input type="checkbox"/> Consume Teas <input type="checkbox"/> Consume Soft Drinks <input type="checkbox"/> Nervous Habits <input type="checkbox"/> Normal |
| 17. | Female ONLY OB-GYN | Hysterectomy Pregnancy: # Age period began: Discharge from Nipple Cholesterol History | <input type="checkbox"/> PMS <input type="checkbox"/> Last PAP date: <input type="checkbox"/> Breast Exam date: <input type="checkbox"/> Mastectomy <input type="checkbox"/> Iron Deficiency | Lumps in Breast Are You Pregnant Yes No Due Date: Dr. Name: Normal |
| 18. | Male ONLY | <input type="checkbox"/> Last PSA Test <input type="checkbox"/> History of Prostate | <input type="checkbox"/> Hernia History/Surgeries <input type="checkbox"/> Cholesterol History | <input type="checkbox"/> Genetic History <input type="checkbox"/> Normal |

I have completed the above survey to the best of my ability.

Signature: _____

Date: _____

Unity Chiropractic, P.C.

Dr. Tricia A. Shaar, D.C., D.A.C.N.B.

TREATMENT AUTHORIZATION RECORD

Consent for Release of Information & Patient Notification Statement

I, _____, hereby authorize Dr. Shaar, and/or her employees, to release to employer groups, insurance companies, government agencies or other third party payers, and their agents, information concerning health care, advice, treatment, supplies or other information that may be necessary for the purpose of determining eligibility, available benefits and obtaining payment on the behalf, for the chiropractic health care provided to me. This authorization may be revoked in writing at any time however revocation will not apply to the previous dates of service. I understand that the care and service I will receive are subject to review by health care professionals, third party payers and review agencies.

I understand that I will be financially responsible for all charges incurred for my treatment if I revoke or refuse to authorize the disclosure of my medical records to a third party payer, and payment denial of my insurance claims results.

Patient Signature _____ Date: _____

CANCELLED OR NO SHOW APPOINTMENTS

All appointments that are cancelled with **less than a 24 hour prior** notice will be subjected to a **\$25.00 fee** for that appointment time slot. An appointment that a **patient fails to show** will be **charged in full**. Payment will be required at the following scheduled appointment.

Initial _____

Unity Chiropractic, P.C.

Dr. Tricia A. Shaar, D.C., D.A.C.N.B.

INFORMED CONSENT FOR CHIROPRACTIC ADJUSTMENTS & CARE

Patient Name: _____ (please print name)

I understand that it is not uncommon that patients have some increased discomfort after an adjustment. If that happens I will apply heat or ice to the area and rest it unless the doctor gave me other specific directions at my visit.

If I am concerned about this discomfort or develop any new symptoms I will call the doctor immediately. If I am out of town or if I am unable to contact the doctor I can present myself to the emergency room or an urgent care as soon as possible.

If any tests were performed outside of this office (other diagnostic procedures) I understand that the doctor will notify me of the results at my next scheduled appointment.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy, electric stimulation – ARPwave therapy, manual therapy and, if necessary, diagnostic x-rays, on me by the doctor and/or any of her qualified staff.

I have had the opportunity to discuss with the doctor the nature and purpose of chiropractic adjustments and other procedures relative to my care. I understand that the results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks with treatment, including, but not limited to muscle strain and sprain, disc injury and cerebrovascular accident. I do not expect the doctor to be able to anticipate and explain all the risks and complications and I wish to rely on the doctor to exercise her best judgment during the course of the procedure which, based upon the facts then known, the doctor feels at the time is in my best interest.

Patient Signature

Date

Unity Chiropractic, P.C.

Dr. Tricia A. Shaar, D.C., D.A.C.N.B.

OFFICE FINANCIAL POLICIES

To prevent any misunderstandings about your insurance coverage and our billing/collections procedures, we like to inform our patients that we can not render services on the assumption that the patient care given will be paid for by an insurance company. **You will be fully responsible for all professional services rendered and furnished that your insurance company does not pay in full. This policy pertains to both major medical insurance cases and/or personal injury/automobile insurance cases.**

For certain insurance plans that we do not participate in, we do reserve the right to NOT bill your insurance company. We will provide you with a receipt so you can submit your own bills.

It is our Office Policy to:

1. To collect full payment for cash patients the day services are rendered. If payment is not collected on day of service the cash discount at the time of service will no longer apply and you will be billed our full standard fee.
2. Collection of all deductibles payments and/or co-pays is done at the time of services rendered.
3. We will accept your insurance office visit co-pay as our in-office co-pay after each treatment, after the deductible has been met; in all cases. If your insurance company does not have designated co-pays of at least \$35.00, our in-office co-pay is \$35.00.
4. If your insurance company payment + your in-office co-pay does not meet Unity Chiropractic at the time of service fees patient will be responsible and billed for the difference plus 15% insurance billing processing fee.
5. You will be charged a late fee of 25% APR, if payment is not received by the due date on the statement.
6. To collect full payment for any nutritional supplies, supports, and any therapeutic appliances the day they are prescribed.
7. We will charge a \$45.00 fee for any returned checks.
8. Phone consultations over 10 minutes have a charge of \$45.00 per 15 minutes.
9. If your major medical insurance policy is a split percentage, ___%/ ___%, we will set a payment to be collected at the time of service that will go towards your deductible. In doing this, we agree to write off any balance (except nutritional supplies, supports, treatment instruments, pillows/wedges or deductibles) not covered by your insurance company. If however, you do not pay this set fee at the time of service, we will bill you for the full percentage as stated in your policy.
10. Patients who have Blue Cross/Blue Shield (BC/BS) PPO out-of-state insurance - **please be advised - that you will receive a check from your insurance company in the mail.** This check will be in your name however this check is not for you. **This is our check and needs to be signed over to Unity Chiropractic.** We are not contracted, in-network with BC/BS and therefore they will pay the patient for the services we have provided. Failure to turn over the check and pay us for the services we have provided will result in the file going to collections.

You signature will signify your understanding and compliance with our policies. Thank you.

Patient Signature: _____ Date: _____

