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 <u>current</u> 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?

_____

_____

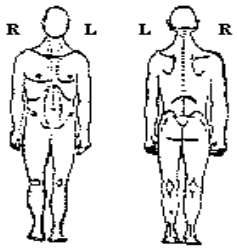
Have you ever sought chiropractic health care before? (Dr.'s name, city or state, length of care, conditions treated, x-rays taken, etc.)

_____

_____

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 <u>at its WORST</u> on the scale below:

0_____10

(absent) (extreme)

Please rate the intensity <u>RIGHT NOW</u> 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.)

_____

_____

<u>ANY CHANGES OR ADDITIONS TO YOUR PAST HEALTH HISTORY</u>

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	☐ Fever ☐ Weight Loss or Gain ☐ Sweats ☐ Low Grade Fever	☐ Chills ☐ Fatigue ☐ Allergies ☐ Frequent Illness	☐ Sleep Disturbances ☐ Water Intake: _____ ☐ Nausea ☐ Normal

Patient: _____ Date: _____

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

Patient: _____ Date: _____

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

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

Signature: _____ **Date:**_____

Unity Chiropractic, P.C.

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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 _____

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.

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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 serves 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 $45.00, our in-office co-pay is $45.00.
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: _____