



WELCOME

To Advanced Spine & Sports Medicine

About You		Today's Date:	
Last Name:		First Name:	MI:
Age:	Date of Birth:	Gender: M / F	SSN:
Married? <input type="checkbox"/> YES <input type="checkbox"/> NO	Spouse's name:	Do you have children? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Home Address:	Email Address:	Home Phone:	Cell Phone:
Employer Name & Address:	Employer Phone:	Occupation:	

Reason For Visit					
The reason for this visit is a result of:	Work	Sports	Auto	Trauma	Chronic
Please Explain:					
Please describe pain & its location:					
Date condition began?	Is your condition: <input type="checkbox"/> Getting sores <input type="checkbox"/> Comes & Goes <input type="checkbox"/> Constant				
How would you describe the type of pain :					
<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Burning <input type="checkbox"/> Shooting <input type="checkbox"/> Stiff <input type="checkbox"/> Numb <input type="checkbox"/> Tingly <input type="checkbox"/> Other:					
Is your condition interfering with:	Sleeping	Work	Daily Routine		
Have you had this or similar conditions in the past? <input type="checkbox"/> YES <input type="checkbox"/> NO					
If yes, please explain:					
Have you been treated by a Medical Physician for this condition? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, where:					
Have you treated with a Chiropractor before? <input type="checkbox"/> YES <input type="checkbox"/> NO					

Responsible for Account					
Please circle the proper box below to indicate how you would like us to file your bills:					
Personal Insurance	Attorney	Third Party (party at fault)	PIP (personal car insurance)	Work Comp	I am a cash
Name & Contact Info:	Name & Contact Info:	Name & Contact Info:	Name & Contact Info:	Name & Contact Info:	

In Event of Emergency		How did you hear about us	
Whom should we contact? Relation:		Friend? Name:	
Home Phone:	Cell Phone:	Attorney? Name:	
Who is your Medical Doctor?	Phone:	Online? Site Name:	

Health History

Please list ALL medications you are currently taking (Prescriptions & Over-The-Counter):

NAME	HOW OFTEN DO YOU TAKE?	CLINICAL REASON

Please ✓ if you have ever had any of the following:

GENERAL		BONE / JOINT	
Cancer	Night Sweats	Back Pain	Fractures
Hepatitis	Unexplained Weight Loss	Gout	Rheumatoid Arthritis
Diabetes	Fatigue	Joint Pain	Osteoarthritis
Thyroid Disease	Anxiety / Panic Attacks	Muscle Cramps	Osteoporosis
Recent Fever	Depression		
EYES/EARS/HEAD	ABDOMEN	URINARY TRACT	BREAST
Migraine Headaches	Peptic Ulcers	Kidney Failure	Mastectomy
Glaucoma	Heartburn	Kidney Stones	Lump
Cataracts	Hernia	Recent Infections	Biopsy
Blindness	GERD	Recurrent Bladder Infections	Fibrocystic Disease
Wear Contact Lenses	Frequent Nausea	Recurrent Kidney Infections	
Partial plate/dentures	Frequent Vomiting	Dialysis	
HEART	LUNGS	NEUROLOGICAL	
Heart Attack	Shortness of breath	History of dizziness	Paralysis
Chest Pain / Angina	Asthma	Alzheimer's	Numbness / Tingling
Heart Failure	Recurrent Bronchitis	Head Injury	Weakness in arms/legs
Heart Murmur	Emphysema	Memory Loss	Seizure
Palpitations	Pulmonary Embolism	Blackout Spells	Epilepsy
Pacemaker	Tuberculosis	Stroke	
High Blood Pressure	Pneumonia		

Other:

List Allergies:

List previous surgeries / treatment with dates:

List any past serious accidents with dates:

Lifestyle Questions:

Do you exercise	<input type="checkbox"/> Never <input type="checkbox"/> Rare <input type="checkbox"/> Occasional <input type="checkbox"/> Weekly <input type="checkbox"/> Several times per week <input type="checkbox"/> Daily Type of Exercise:
How much are you on your feet	<input type="checkbox"/> 10% <input type="checkbox"/> 25% <input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> 100%
Use of Alcohol	<input type="checkbox"/> Rare <input type="checkbox"/> Occasional <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Never <input type="checkbox"/> No longer
Use of Tobacco	<input type="checkbox"/> Yes, _____ Packs/day <input type="checkbox"/> Quit /How long ago _____ <input type="checkbox"/> Never
Do you use Recreation drugs	<input type="checkbox"/> Never <input type="checkbox"/> Rare <input type="checkbox"/> Occasional <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Quit/How long ago _____ Type:

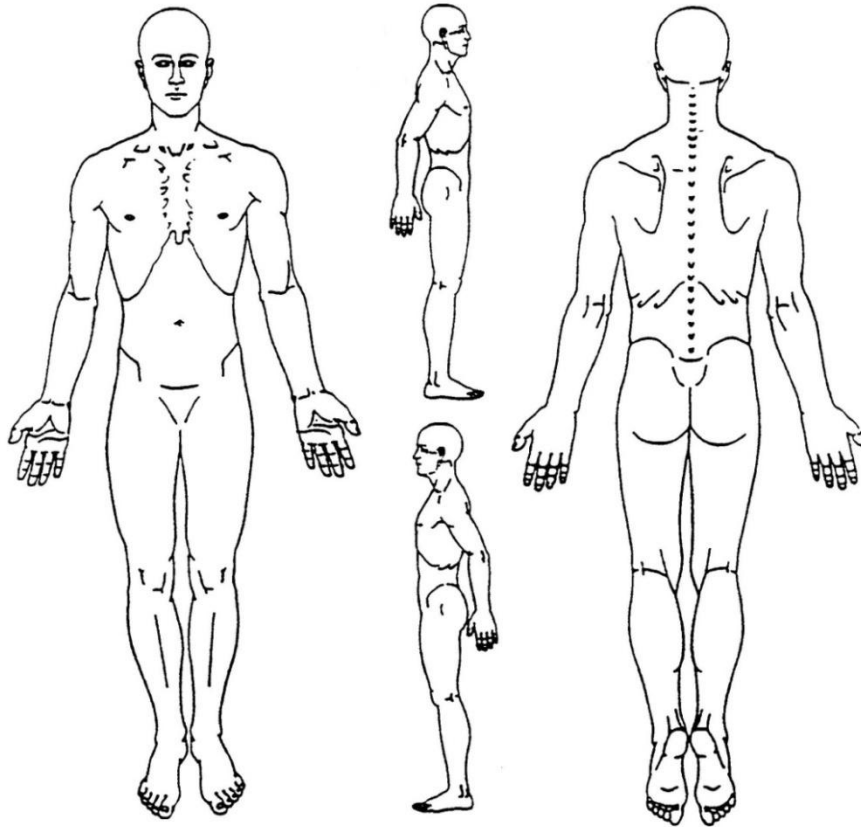
For Women:

Taking birth control	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you pregnant	If yes, how far along?
Nursing	<input type="checkbox"/> YES <input type="checkbox"/> NO

ADVANCED SPINE & SPORTS MEDICINE

On the drawings below, please indicate where you are experiencing pain by drawing in the letter abbreviation(s) that most accurately reflects the type of discomfort that you have been experiencing.

N	T	A	P	B	S
Numbness	Tingling	Dull Ache	Sharp Pain	Burning	Stiffness



Please Estimate Your Pain Level

(Circle the number accordingly)

Ex: <u>Low Back</u>	0 = No Pain	0 1 2 3 ④ 5 6 7 8 9 10	10 = Intolerable
<u>Body area:</u>	0 = No Pain	0 1 2 3 4 5 6 7 8 9 10	10 = Intolerable
<u>Body area:</u>	0 = No Pain	0 1 2 3 4 5 6 7 8 9 10	10 = Intolerable
<u>Body area:</u>	0 = No Pain	0 1 2 3 4 5 6 7 8 9 10	10 = Intolerable
<u>Body area:</u>	0 = No Pain	0 1 2 3 4 5 6 7 8 9 10	10 = Intolerable

Name: _____ Date: _____

ADVANCED SPINE & SPORTS MEDICINE

4801 Spring Valley road • Dallas, Texas 75244 • 972-488-9686

Name: _____

Today's Date: _____

Patient Acknowledgement Form

ALL PATIENTS	
Initial: _____	I understand all out-of-pocket fees are due at time of visit
Initial: _____	A 24 hour cancelation notice is required. You will be charged a 50% fee if you fail to provide a 24 hour notice
Initial: _____	MASSAGE SERVICES: Once your massage is scheduled a timed-slot is blocked for you. If you should arrive late this will shorten your massage time. However, you will still owe for the time blocked as you requested when the appointment was scheduled.

INSURANCE PATIENTS ONLY	
Initial: _____	Advanced Spine & Sports Medicine allows 60 days for your insurance to pay on filed claims
Initial: _____	Advanced Spine & Sports Medicine will dispute Insurance denials up to 3 times. If a denial is not resolved after the third attempt, the claim becomes the patient's responsibility and payment arrangements must be made.
Initial: _____	The patient is responsible for understanding all insurance information pertaining to his/her benefits, including coverage, co-pays, max visits allowed, and non-covered services. In the event that you treat outside your allowed benefits you will be responsible for the charges
Initial: _____	In the event that a Doctor-recommended service, necessary service, or a patient-requested service is not covered by your insurance, an additional out-of-pocket cost will be required

Signature: _____ Date: _____

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Advance Beneficiary Notice of Noncoverage (ABN)

NOTICE: Medicare does not pay for everything. The services listed in box D are services we provide in this office but are not covered by Medicare. Regardless that the particular service is recommended by your healthcare provider and/or you have good reason to think you could benefit from this service.

If you choose one or more of the services listed in box D, you may have to pay out-of-pocket.

D	E (Reason Medicare may not pay)	F (Estimated Cost)
<ul style="list-style-type: none">• Manual Therapy• Therapeutic Exercise• Initial Evaluation• Office Visits and Exams• Acupuncture• Massage	When Physical Therapy, Massage Therapy, Manual Therapy, and exams are provided within a Chiropractic Clinic, Medicare will not cover the services.	\$20 - \$130

SPECIAL INSTRUCTIONS

1. Read this notice, so you can make an informed decision about your care
2. Ask any questions that you may have once you finish reading this form
3. Choose an option below

NOTE: should you choose option 1 or 2, we might be able to help you with other filing options (another insurance if available). However, Medicare does not require us to do so

OPTIONS: Check only one box. We cannot choose a box for you, **but option 2 is the likely option**

Option 1: I want the treatment _____ listed above (box D). You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

Option 2: I want the treatment _____ listed above (box D), but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

Option 3: I do not want any of the treatment listed above in box D. I understand that with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-633-4227 / TTY: 1-877-486-2048). Signing below indicates that you have received and understand this notice and were also offered a copy.

Signature of Patient / Responsible Party

Date:

Notice Given By: _____

ADVANCED SPINE & SPORTS MEDICINE

Dr. Jason Jodoin D.C.

The Nature of Chiropractic Treatment offered at Advanced Spine & Sports Medicine

Chiropractic treatment consist of evaluation, diagnosing and treating the conditions warranted through the means of using hands, mechanical instruments, various modalities as well as the use and instruction of exercise and/or stretching. When manipulations are performed, you may feel joint movement and you may hear joints "click" or other sounds. Some patients will feel some soreness and/or stiffness following the first few days after treatment. These are normal and not a cause for concern.

Informed Consent for Chiropractic

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named above, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed and that each individual responds differently to the treatment.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

Relative Contraindications: Adds significant risk of injury to the patient but does not rule out the use of dynamic trust. These conditions include: articular hypermobility, severe bone demineralization, benign bone tumors, bleeding disorders, anticoagulant therapy, progressive radiculopathy (meaning weakness, muscle loss, bowel/bladder symptoms).

Absolute Contraindications: Manipulation (including low force techniques) is absolutely contraindicated when the following are present: acute arthropathy, acute/unstable fractures, unstable dens, malignancy of the spine/involved region, infections of the spine, myelopathy, VBS in the cervical spine, arterial aneurysm in the area.

I understand and acknowledge that untreated conditions warranted for chiropractic care allows for adhesions, scar tissue, and other degenerative changes to occur. These changes can further reduce skeletal mobility and can cause chronic pain cycles. In addition, it is quite probable that the delaying or not following the recommendations of the doctor will complicate the condition and make future rehabilitation more difficult.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Signature _____ Date _____

Print Name: _____

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Acknowledgment of receipt of Notice of Privacy Practice

Pf-2000

Advanced Spine & Sports Medicine* reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the notices of Privacy Practices for Advanced Spine & Sports Medicine*.

Patient's Name (print): _____

Patient's Signature: _____ Date: _____

Representative of patient Signature: _____

(Required if the patient is a minor or an adult who is unable to sign this form)

Documentation of Attempts to Obtain Acknowledgement of Receipt of Notice of Privacy Practice

PF - 2100

Attempt to Obtain Acknowledgement

An attempt was made to obtain an acknowledgment of receipt of the Notice Privacy Practices on _____ . The acknowledgement was not obtained because:

<input type="checkbox"/>	The Patient was undergoing emergency treatment
<input type="checkbox"/>	The patient declined to sign the acknowledgment
<input type="checkbox"/>	Other:

Name of patient (print): _____

Name of Staff Member: _____ Date: _____