

Welcome to Angelo Chiropractic & Acupuncture

Thank you for choosing our office for your healthcare needs. We will determine if Chiropractic/Acupuncture and its associated treatments are best suited for you. We strive to provide the highest quality of care possible. If our modes of care are not indicated, or need to be co-managed we will recommend a healthcare practitioner to best serve your needs.

Angelo Chiropractic & Acupuncture treats patients of all ages, backgrounds, and needs--- including families, athletes, newborns, expecting mothers, the injured and sick, and those who wish to maintain their health. We are HIPPA compliant; we will not release your medical information without written consent from you. A Privacy Policy and informed consent will be provided for your protection and review.

Payment Policy

Payment is due/expected for fees incurred on the date of service, including co-pays, deductibles, coinsurance, or remaining balance. Full payment is due until benefits are verified unless other arrangements are made. Payment is accepted by CASH, CHECK OR CREDIT CARD.

Insurance and Managed Care

We are contracted providers for many local plans; our participation in these plans can vary year to year. If you are under a managed care plan or health, coverage of this plan will be explained to you once verified. A quote of verification of your benefits is not a guarantee, but a general quote or estimate. This cannot be completely confirmed until the first claim is submitted and paid within thirty days from your first appointment. Benefits of your plan for Chiropractic can vary by policy. Some have limits on visits per year or dollar limits per year. These benefits may or may not cover your specific needs. We will inform you of your needs and allow you to make an informed decision. Know always that we treat patient is needs and not their insurance policy. Care beyond plan limits is the responsibility of the patient. Acupuncture, orthotics, bracing, supplements, herbs, and vitamins are on a self-pay basis. A receipt can be given for insurance or use for an HSA account.

Medicare

Traditional Medicare covers ONLY spinal manipulation provided by a Chiropractic Physician., up to twenty-four visits per calendar year at 80% of the charge once the yearly deductible is met. The remaining 20% is covered by either a secondary policy or by the patient at the time of visit. Medicare DOES NOT cover x-rays, lab work, physical therapy (i.e., traction, electrical therapy, ultrasound, massage). These costs are the responsibility of the patient at the time of service. Medicare Select plans operate like private insurance and vary from policy to policy on deductible amount, and what is covered.

Privacy Practices

This office is required to notify you in writing that by law, we must maintain the privacy and confidentiality of your personal health information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we

are permitted to disclose information about you to a third party without your authorization. Below is a summary of these circumstances.

Permitted Disclosure

Treatment Purposes-discussion with other health care providers involved in your care.

Inadvertent Disclosures-discussion in open office area.

For Payment Purposes-to obtain payment from your insurance company or another source.

Emergency-in the event of an emergency, we may contact a family member.

For Public Health or Safety-in order to prevent or lessen a serious eminent threat to the public.

Telephone Calls and Appointment Reminders-we may call, text, or leave messages regarding appointments, testing, practice hours or upcoming events.

Change of Ownership-in the event this practice is sold, the new owners would have access to your personal health information.

Personal injury/Automobile accidents

If you have been involved in an accident inform us immediately. Accidents require specific documentation, examination, and specific billing procedures. Incorrect documentation could affect a patient's case (i.e., treatment, lost wages, settlements, etc.) Once the claim is settled or if you suspend or terminate care, fees for services are due immediately. A person's PIP (Personal Injury Protection with car insurance) can be used for healthcare. We also accept LOP's (Letter of Protection) from certain attorneys we have worked with previously.

Timely appointments

I understand that when reserving an appointment that I and my doctor are reserving time for my care, and if not utilized prevents another from receiving care. Therefore, for Angelo Chiropractic and Acupuncture to provide timely service to all patients, this office requires a 12- hour minimum cancelation notice, the charge will be for an office visit if not adhered to. Recurrent no shows or reschedules will be required to keep a credit card on file.

Signature states understanding of all written policy and conveys any assignment of insurance benefits to Angelo Chiropractic & Acupuncture Center.

Signature of Patient, Parent or Guardian

Date

Application for Treatment Confidential Patient Information

Date: _____
 Whom may we thank for referring you? _____
 Name: _____ Email: _____
 Cell Phone: _____ Home Phone: _____
 Address: _____ Zip Code: _____
 City: _____ State: _____ Age: _____ Date of Birth: _____
 Height: _____ Weight: _____ Marital Status: M W S D Number of Children: _____
 Occupation: _____ Employed by: _____
 Spouse Name: _____ Phone Number: _____
 Contact in Case of Emergency: _____ Phone number: _____
 Reason(s) for Visit: _____

On a scale of **1** to **10** with **10** being the worst pain and zero being no pain, rate your above complaints by **circling the number**:

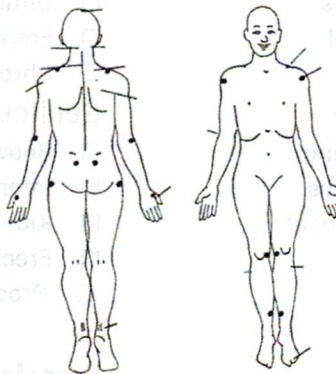
Primary or chief complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Secondary complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

How long does it last? ☐ Constant ☐ On & Off During the Day ☐ Comes & Goes Throughout the Week

PLEASE MARK the areas on the Diagram with the follows **letters** to describe your symptoms:

R = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness **S** = Sharp/Stabbing **T** = Tingling



When did it first appear? _____

Have you had this condition previously? _____

Is this condition getting progressively worse? Yes No

Does your condition interfere with (circle all that apply): Work Sleep Bending Reaching

Digestion Menstruation Mental Status Bowel/Bladder Function Sex Drive

Have you been treated by any physician/health provider for this condition? _____

Are you allergic to any medications or foods? _____

Are you taking medications, supplements or vitamins? _____

Surgeries? _____

How would you rate your overall health?

Worst you have ever been

Best you have ever been

Smoking: ☐ Cigars ☐ E-Cigarette ☐ Cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

Alcoholic Beverage: Consumption Occurs? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

Recreational Drug Use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

Exercise / Recreational Activities: ☐ Daily ☐ 3+ Weekly ☐ 1x Weekly ☐ Never

Caffeine drinks (per day/week)? _____

Review of Systems: (Please mark/circle all that are applicable)

Neurological

- ☐ Allergies
- ☐ Anxiety
- ☐ Depression
- ☐ Dizziness
- ☐ Nervousness
- ☐ Numbness
- ☐ Loss of Sleep
- ☐ Pins & Needles

Muscle & Joint

- ☐ Arthritis
- ☐ Bursitis
- ☐ Foot/Ankle Pain
- ☐ Hip Disorders
- ☐ Knee Pain
- ☐ Neck Pain
- ☐ Poor Posture
- ☐ Scoliosis
- ☐ TMJ Disorder
- ☐ Low Back Pain

Digestive

- ☐ Excessive Gas
- ☐ Colon Problems/IBS
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Gall Bladder/Liver Trouble
- ☐ Anorexia/Bulimia
- ☐ Ulcers

Cardiovascular

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Rapid Heartbeats
- ☐ High Cholesterol
- ☐ Pain Over Heart
- ☐ Poor Circulation
- ☐ Excessive Bruising
- ☐ Swelling of Ankles
- ☐ Abnormal Heartbeat
- ☐ Varicose Veins

Eyes, Ears, Nose & Throat

- ☐ Ear Infection
- ☐ Eye Infection
- ☐ Sore Throat
- ☐ Sinus Infection
- ☐ Tonsillitis
- ☐ Ringing in ears
- ☐ Hearing Loss
- ☐ Swelling of Ankles

Respiratory

- ☐ Asthma
- ☐ Apnea
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Chronic Cough

Genitourinary

- ☐ Bedwetting
- ☐ Infertility
- ☐ Kidney Infection
- ☐ Erectile Dysfunction
- ☐ Prostate Issues

Skin

- ☐ Acne
- ☐ Dryness
- ☐ Eczema
- ☐ Rash
- ☐ Yeast/Fungus

Constitutional

- ☐ Fainting
- ☐ Fatigue
- ☐ Low Libido
- ☐ Poor Appetite
- ☐ Weakness

Female

- ☐ Heavy Flow
- ☐ Heavy Cycle
- ☐ Painful Cycle
- ☐ Discharge
- ☐ Menopausal

Yes No

Other

- | | | | | |
|---|------------------------------------|------------------------------------|---|---|
| ☐ Acid Reflux | ☐ AIDS | ☐ Anemia | ☐ Alcoholism | ☐ Arnold Chiari |
| ☐ Autism | ☐ ADHD | ☐ Cancer | ☐ Diabetes | ☐ Epilepsy |
| ☐ Fibromyalgia | ☐ Gout | ☐ Glaucoma | ☐ Heart Disease | ☐ Multiple Sclerosis |
| ☐ Herniated Disc | ☐ Hepatitis | ☐ Migraines | ☐ Spine Degeneration | ☐ Rheumatoid Arthritis |
| ☐ Other: _____ | | | | |

Your Goals For Care:

- | | |
|--|--|
| ☐ Feel better quickly/pain relief | ☐ Feel better and prevent its return |
| ☐ Have a healthier spine/nervous system | ☐ I want optimum health and to live a healthier lifestyle |

Patient Agreement

Our Policy requires payment in full for all services at the time of service, unless other arrangements have been made with our office. Insurance must be verified before acceptance for payment. Any services not covered by insurance is due within thirty days.

Signature of Patient, Parent, or Guardian: _____

Date: _____

Please be courteous and silence/turn off cell phones. We ask that you please arrive promptly to your appointment, all arrivals 10 minutes after appointment time will be rescheduled.

Thank you for allowing us to help with your health!