CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Back to Health Chiropractic, P.C.
Dr. Molly (Maureen) Keefe
387 Lake Road Suite 3
Saint Albans, VT 05478
(802) 527-BACK(2225)
www.drmolly.com
Gentle, Effective & Caring

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?
O No O Yes **When?**

Whom may we thank for referring you?

If so, whom?

Gender
O Male O Female

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (or Initial)

Birth Date (MM/DD/YYYY)

Marital Status
O Single O Married O Divorced
O Widowed O Separated

Address

City | State/Province | ZIP/Postal Code | Home Phone | Spouse's Name

Email Address | Cell Phone | Child's Name and Age

Emergency Contact | Phone | Child's Name and Age

Your Occupation | Child's Name and Age

Your Employer

May we contact you at work?
O Yes O No

Address

City | State/Province | ZIP/Postal Code | Work Phone

Insurance Carrier | Policy Number | Primary Care Provider's Name

Insured's Last Name

Who carries this policy?
O Self O Spouse O Parent

First Name | Middle Name (or Initial)

Insured's Employer

Address

City | State/Province | ZIP/Postal Code | Employer's Phone

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1. The symptom(s) that have prompted me to seek care today include: ______

Patient name ______

2. And are the result of (darken circle): ○ An accident or injury
○ Work ○ Auto ○ Other ______
○ A worsening long-term problem
○ An interest in: ○ Wellness ○ Other ______

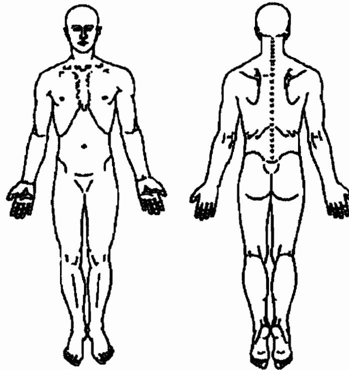
3. Onset (When did you first notice your current symptoms?) ______

4. Intensity (How extreme are your current symptoms?)
0 ○-○-○-○-○-○-○-○-○-○ 10
Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?)
○ Constant ○ Comes and goes. How Often? ______

6. Quality of symptoms (What does it feel like?)
- ○ Numbness
- ○ Tingling
- ○ Stiffness
- ○ Dull
- ○ Aching
- ○ Cramps
- ○ Nagging
- ○ Sharp
- ○ Burning
- ○ Shooting
- ○ Throbbing
- ○ Stabbing
- ○ Other ______

7. Location (Where does it hurt?) Circle the area (s) on the illustration.
"O" for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.) ______

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)
What tends to worsen the problem? ______
What tends to lessen the problem? ______

10. Prior interventions (What have you done to relieve the symptoms?)
○ Prescription medication ○ Surgery ○ Ice
○ Over-the-counter drugs ○ Acupuncture ○ Heat
○ Homeopathic remedies ○ Chiropractic Other ______
○ Physical therapy ○ Massage ______

11. What else should Dr. Keefe know about your current condition? ______

12. How does your current condition interfere with your:

Work or career: ______

Recreational activities: ______

Household resposibilities: ______

Personal relationships: ______

Consultation Notes

13. Review of Systems
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Osteoporosis	○	○	Arthritis	○	○	Scoliosis	○	○	Neck pain	○	○	Back problems	○	○	Hip disorders	NONE ○
○	○	Knee injuries	○	○	Foot/ankle pain	○	○	Shoulder problems	○	○	Elbow/wrist pain	○	○	TMJ issues	○	○	Poor posture	Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Anxiety	○	○	Depression	○	○	Headache	○	○	Dizziness	○	○	Pins and needles	○	○	Numbness	NONE ○ Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	High blood pressure	○	○	Low blood pressure	○	○	High cholesterol	○	○	Poor circulation	○	○	Angina	○	○	Excessive bruising	NONE ○ Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Asthma	○	○	Apnea	○	○	Emphysema	○	○	Hay fever	○	○	Shortness of breath	○	○	Pneumonia	NONE ○ Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Anorexia/bulimia	○	○	Ulcer	○	○	Food sensitivities	○	○	Heartburn	○	○	Constipation	○	○	Diarrhea	NONE ○ Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Blurred vision	○	○	Ringing in ears	○	○	Hearing loss	○	○	Chronic ear infection	○	○	Loss of smell	○	○	Loss of taste	NONE ○ Initials ____

g. Integumentary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Skin cancer	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○	○	Hair loss	○	○	Rash	NONE ○ Initials ____

Doctor's Initials ______

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(Continued from previous page)

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	Thyroid issues	O	O	Immune disorders	O	O	Hypoglycemia	O	O	Frequent infection	O	O	Swollen glands	O	O	Low energy

NONE O Initials ____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	Kidney stones	O	O	Infertility	O	O	Bedwetting	O	O	Prostate issues	O	O	Erectile dysfunction	O	O	PMS symptoms

NONE O Initials ____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	Fainting	O	O	Low libido	O	O	Poor appetite	O	O	Fatigue	O	O	Sudden weight change	O	O	Weakness

NONE O Initials ____

Patient name

O All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
O	O	AIDS	O	O	Tuberculosis
O	O	Alcoholism	O	O	Typhoid fever
O	O	Allergies	O	O	Ulcer
O	O	Arteriosclerosis	O	O	Other: ____
O	O	Cancer			____
O	O	Chicken pox			____
O	O	Diabetes			____
O	O	Epilepsy			____
O	O	Glaucoma			____
O	O	Goiter			____
O	O	Gout			____
O	O	Heart disease			____
O	O	Hepatitis			
O	O	Malaria			
O	O	Measles			
O	O	Multiple Sclerosis			
O	O	Mumps			
O	O	Polio			
O	O	Rheumatic fever			
O	O	Scarlet fever			
O	O	Sexually transmitted disease			
O	O	Stroke			

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- O Appendix removal
- O Bypass surgery
- O Cancer
- O Cosmetic surgery
- O Elective surgery: ____
- O Eye surgery
- O Hysterectomy
- O Pacemaker
- O Spine ____
- O Tonsillectomy
- O Vasectomy
- O Other: ____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
O	O	Acupuncture
O	O	Antibiotics
O	O	Birth control pills
O	O	Blood transfusions
O	O	Chemotherapy
O	O	Chiropractic care
O	O	Dialysis
O	O	Herbs
O	O	Homeopathy
O	O	Hormone replacement
O	O	Inhaler
O	O	Massage therapy
O	O	Physical therapy
O	O	Nutritional supplements:

List: ____

O	O	Medications (prescription and over-the-counter):

____

17. Injuries

Have you ever...

O	Had a fractured or broken bone	O	Used a crutch or other support
O	Had a spine or nerve disorder	O	Used neck or back bracing
O	Been knocked unconscious	O	Received a tattoo
O	Been injured in an accident	O	Had a body piercing

Consultation Notes

18. Family History

Some health issues are hereditary. Tell Dr. Keefe about the health of your immediate family members.

FAMILY

Relative	Age (If living)	State of health: Good	Poor	Illnesses	Age at death	Cause of death: Natural	Illness
Mother	____	O	O	____	____	O	O
Father	____	O	O	____	____	O	O
Sister 1	____	O	O	____	____	O	O
Sister 2	____	O	O	____	____	O	O
Brother 1	____	O	O	____	____	O	O
Brother 2	____	O	O	____	____	O	O
____	____	O	O	____	____	O	O

19. Are there any other hereditary health issues that you know about? ____

____

20. Social History

Tell Dr. Keefe about your health habits and stress levels.

SOCIAL

Alcohol use	O Daily	O Weekly	How much? ____
Coffee use	O Daily	O Weekly	How much? ____
Tobacco use	O Daily	O Weekly	How much? ____
Exercising	O Daily	O Weekly	How much? ____
Pain relievers	O Daily	O Weekly	How much? ____
Soft drinks	O Daily	O Weekly	How much? ____
Water intake	O Daily	O Weekly	How much? ____

Hobbies: ____

Prayer or meditation?	O Yes	O No
Job pressure/stress?	O Yes	O No
Financial peace?	O Yes	O No
Vaccinated?	O Yes	O No
Mercury fillings?	O Yes	O No
Recreational drugs?	O Yes	O No

Doctor's Initials

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21. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

Activity	No Affect	Mild Affect	Moderate Affect	Severe Affect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

22. What is the major stressor in your life? ____________________

23. How much sleep do you average per night? ______ Hours

24. What is the type and approximate age of your mattress and pillow? ____________________

25. What is your preferred sleeping position? ____________

26. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

27. What would be the most significant thing that you could do to improve your health? ____________________

28. In addition to the main reason for your visit today, what additional health goals do you have? ____________________

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): ____________**

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

If the patient is a minor child, print child's full name: ____________________

____
Signature

____
Date (MM/DD/YYYY)

Patient name

Consultation Notes

Doctor's Initials

Back to Health Chiropractic, P.C.
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PRIVACY PRACTICES ACKNOWLEDGEMENT
PATIENCT RECORD OF DISCLOSURES

Acknowledgement Form

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (*PHI*). The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone: ____________________

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone ______________________

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication

- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

☐ Other ____________________________

____

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_______________________________ Patient Signature

_______________________________ Date

_______________________________ Print Name

_______________________________ Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate health record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency

Back to Health Family Chiropractic

Payment for Services and Supplies Rendered

This is the fun part about our **Financial Policy.** We work hard to keep the cost of chiropractic care down and affordable. You, our wonderful patients, can help us accomplish this by paying your co-pay and any outstanding balances owed at the time of service. The following is a summary of our payment policy.

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Yes, this is true. We require payment at the time we provide services unless other arrangements have been made in advance. This includes applicable deductibles, co-insurances (your percentage of the balance due) and co-pays for participating insurance companies. We accept cash, local checks, debit cards and credit cards; Visa, MasterCard and Discover. There is a $25.00 service charge for returned checks, and we reserve the right to charge a $5.00 processing/administrative statement fee for non-payment of co-pays at the time of service.

We do understand extenuating circumstances may occasionally cause financial hardship. Please call or speak personally with our Billing Specialist to discuss a reasonable payment agreement.

INSURANCE COVERAGE

At the time of your visit, you will be asked to provide your medical insurance card for correct claim processing. As a courtesy to our patients, we process claims for any insurance group in which we are considered participating providers. (This means we have reached a contractual agreement with them for payment of services Back to Health Chiropractic provides to their members.) You are expected to pay your deductible and co-payments or co-insurance ***at the time of service*** whether we are a participating provider or not. If we have not received payment from your insurance company within 45 days, (2 billing cycles), you will be expected to pay the balance in full. You are ultimately responsible for all charges incurred. If your insurance company denies payment for any reason other than an error on our part, it is ***your*** responsibility to follow up with them to appeal. We will not research denials for you unless it is caused by an error within our office. We will be happy to resubmit charges, once you have researched a solution with a representative from your insurance company.

We will gladly bill secondary insurances if we are on their list of participating providers and you notify us that you have a secondary insurance at the time of service.

If we do not participate with your company, or you cannot provide proof of medical insurance coverage, it is expected you will make payment at the time of service.

REFERRALS

If Dr. Molly determines you need to be seen by a specialist, it is your responsibility to check with your insurance carrier to determine if a Referral or Prior Authorization is required. There are numerous levels of coverage and policy requirements within each carrier/company. Our staff is not responsible for knowing whether or not your policy has these requirements, however; they will help you and your provider process the referral.

MISSED OR "NO SHOW" APPOINTMENTS OR LATE CANCELLATIONS

When you miss a scheduled appointment, or cancel it close to the appointed time, it represents a cost to you, to us and to the other patients. We request 24 hour notice if you can not make an appointment. We reserve the right to charge a $25.00 fee for missed or late cancelled appointments. If the late cancellation is due to an emergency or the weather, there would be no charge. A no-show appt is subject to a $50 charge. Excessive missed or "no-show" appointments will sadly result in discharge from the Back to Health practice.

CUSTODIAL PARENTS

By law, you are responsible for payment of your child's medical bills, even if you are not the subscriber of the insurance policy that covers your child's medical services.

SIGNATURE

I have read and understand Back to Health Family Chiropractic's Financial Policy. I agree I am responsible for the balance of my account for any professional chiropractic services rendered. I certify the patient information given is true and accurate to the best of my knowledge. I also agree that if it becomes necessary to forward my account to a collection agency, I will be responsible for any fees incurred by the collection agency, in addition to any amount owed for services.

______________________________ ______________________

Signature of insured / responsible representative Date

______________________________ ______________________

Witness Date

Back to Health Family Chiropractic

Instructions: Fill in Your Name and Name of All Drugs and Vitamins/Supplements You are taking

Patient: ______________________

(for office Use Only Italic Categories) *ordered*

DRUG	*Depletes/Interfers with*	*Cost*	*YES*	*NO*
Name:				
Purpose:				
Name:				
Purpose:				
Name:				
Purpose:				
Name:				
Purpose:				
Name:				
Purpose:				
Name:				
Purpose:				

Vitamin/Supplement	HELPFUL (circle one)		Patient Comments
Name:	Yes	No	
Purpose:	Somewhat	I don't know	
Name:	Yes	No	
Purpose:	Somewhat	I don't know	
Name:	Yes	No	
Purpose:	Somewhat	I don't know	
Name:	Yes	No	
Purpose:	Somewhat	I don't know	
Name:	Yes	No	
Purpose:	Somewhat	I don't know	
Name:	Yes	No	
Purpose:	Somewhat	I don't know	

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** __________ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** __________ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** __________ listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** __________ listed above. 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 **D.** __________ listed above, 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 don't want the **D.** __________ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

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

I. Signature:	J. Date:

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