Siegenthaler Chiropractic Center

2323 Oregon Pike, Lancaster, PA 17601
Phone: (717) 569-6099 (717) 569-8905
SMS (text): (717) 454-3444

NEW PATIENT INFORMATION

Name: ______________________________ **SS#:** ________________
DOB: ___________ **Sex:** [ ] **Male** [ ] **Female**

Address: ____
City: ___________________________ **State:** _____ **Zip:** _____________

Home #:____________________________
Cell #: _____________________________
Work #:____________________________
Email Address: ______________________

Emergency Contact: __________________ **Relationship:** _____________
Home #: _____________________ **Cell #:** ________________

Insurance Carrier: _____________________________
Policy/ID #: ______________________
Group #: _______________________
Subscriber: _____________________

Chief Complaint: ____

Have you been treated for this condition before? Yes □ **No** □
If so, when? ____________ **By Whom:** ______________________________

Is this a result of a workers comp injury or auto accident? Yes□ **No**□

Do you have access to recent x-rays? Yes□ **No**□

Whom may we thank for referring you to our office: ___________________

Notes:____
____
____

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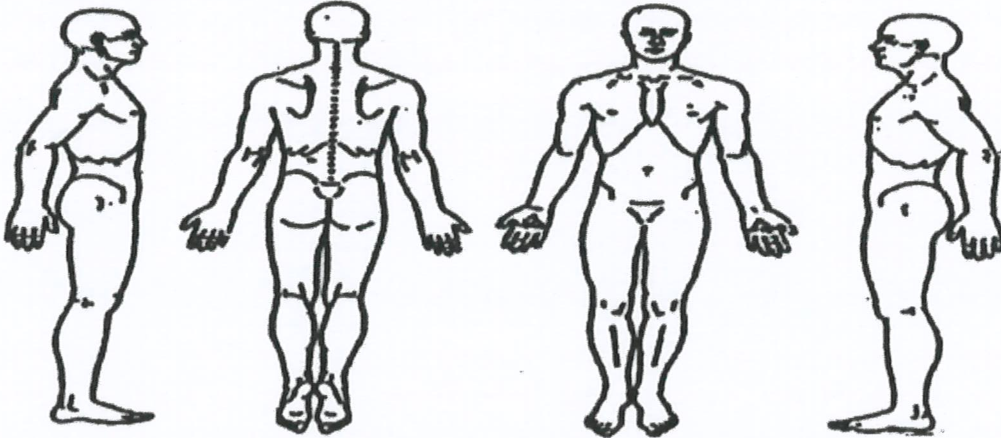
PATIENT INTAKE FORM

Patient Name: ______________________________ Date: _______________

1. Indicate on the drawings below where you have pain/symptoms



2. How often do you experience your symptoms?

- □ Constantly (76-100% of the time)
- □ Occasionally (26-50% of the time)
- □ Frequently (51-75% of the time)
- □ Intermittently (1-25% of the time)

3. How would you describe the type of pain? <u>(Specify symptom to location, if multiple sites)</u>

Descriptor:	Location:	Descriptor:	Location:
Sharp	____________________	Numb	____________________
Dull	____________________	Tingly	____________________
Diffuse	____________________	Sharp with motion	____________________
Achy	____________________	Shooting with motion	____________________
Burning	____________________	Stabbing with motion	____________________
Shooting	____________________	Electric like with motion	____________________
Stiff	____________________	Other: ________________	

4. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

5. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

6. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

7. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

8. Who else have you seen for your problem?

- □ Chiropractor
- □ ER physician
- □ Massage Therapist
- □ Neurologist
- □ Orthopedist
- □ Physical Therapist
- □ Primary Care Physician
- □ Other: ____________
- □ No one

9. How long have you had this problem? ____________

10. How do you think your problem began?

____

11. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

12. What aggravates your problem?

____

13. What alleviates your problem (if anything)?

____

14. What concerns you the most about your problem; what does it prevent you from doing?

____

15. What is your: **Height:** _____ft. ______ in. **Weight** _____________

Occupation _______________________________

16. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?

□ Strenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:

- □ Rheumatoid Arthritis
- □ Heart Problems
- □ Diabetes
- □ Cancer
- □ Lupus
- □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present
□	□ Headaches
□	□ Neck Pain
□	□ Upper Back Pain
□	□ Mid Back Pain
□	□ Low Back Pain
□	□ Shoulder Pain
□	□ Elbow/Upper Arm Pain
□	□ Wrist Pain
□	□ Hand Pain
□	□ Hip Pain
□	□ Upper Leg Pain
□	□ Knee Pain
□	□ Ankle/Foot Pain
□	□ Jaw Pain
□	□ Joint Pain/Stiffness
□	□ Arthritis

Past	Present
□	□ High Blood Pressure
□	□ Heart Attack
□	□ Chest Pains
□	□ Stroke
□	□ Angina
□	□ Kidney Stones
□	□ Kidney Disorders
□	□ Bladder Infection
□	□ Painful Urination
□	□ Loss of Bladder Control
□	□ Prostate Problems
□	□ Abnormal Weight Gain/Loss
□	□ Loss of Appetite
□	□ Abdominal Pain
□	□ Ulcer
□	□ Hepatitis

Past	Present
□	□ Diabetes
□	□ Excessive Thirst
□	□ Frequent Urination
□	□ Smoking/Tobacco Use
□	□ Drug/Alcohol Dependance
□	□ Allergies
□	□ Depression
□	□ Systemic Lupus
□	□ Epilepsy
□	□ Dermatitis/Eczema/Rash
□	□ HIV/AIDS

For Females Only

Past	Present
□	□ Birth Control Pills
□	□ Hormonal Replacement
□	□ Pregnancy

Past	Present		Past	Present	
☐	☐	Rheumatoid Arthritis	☐	☐	Liver/Gall Bladder Disorder
☐	☐	Cancer	☐	☐	General Fatigue
☐	☐	Tumor	☐	☐	Muscular Incoordination
☐	☐	Asthma	☐	☐	Visual Disturbances
☐	☐	Chronic Sinusitis	☐	☐	Dizziness
☐	☐	Other: ______________________			

20. List all prescription medications you are currently taking:

____

21. List all of the over-the-counter medications you are currently taking:

____

22. List all surgical procedures you have had:

____

23. What activities do you do at work?

☐ **Sit:**	☐ Most of the day	☐ Half the day	☐ A little of the day
☐ **Stand:**	☐ Most of the day	☐ Half the day	☐ A little of the day
☐ **Computer work:**	☐ Most of the day	☐ Half the day	☐ A little of the day
☐ **On the phone:**	☐ Most of the day	☐ Half of the day	☐ A little of the day

24. What activities do you do outside of work?

____

25. Have you ever been hospitalized? ☐ No ☐ Yes

if yes, why ____

26. Have you ever seen a chiropractor before? ____________

If yes, how long ago? ____________

How did you feel the results from treatment were? (circle one) Great Good Fair Mixed Poor

Other: __________

27. Have you had significant past trauma? ☐ No ☐ Yes

28. Anything else you would like the doctor to know today?

____

Patient Signature___________________________ **Date:** ________________

NECK DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much of your pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.*

SECTION 1 – *Pain Intensity*

A. I have no pain at the moment
B. The pain is very mild at the moment
C. The pain is moderate at the moment
D. The pain is fairly severe at the moment
E. The pain is very severe at the moment
F. The pain is the worst imaginable at the moment

SECTION 2 – *Personal Care (Washing, Dressing, etc)*

A. I can look after myself normally without extra pain
B. I can look after myself normally, but it causes extra pain
C. It is painful to look after myself and I am slow and careful
D. I need some help, but manage most of my personal care
E. I need help daily in most aspects of self-care
F. I do not get dressed, I wash with difficulty and stay in bed

SECTION 3 – *Lifting*

A. I can lift heavy weights without extra pain
B. I can lift heavy weights, but it causes extra pain
C. Pain prevents me from lifting heavy weights off the floor, but I can manage if conveniently positioned (e.g. on a table, etc.)
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
E. I can lift very light weights
F. I can't lift or carry anything at all

SECTION 4 – *Reading*

A. I can read as much as I want to with no pain in my neck
B. I can read as much as I want to with slight pain in my neck
C. I can read as much as I want to with moderate pain in my neck
D. I can't read as much as I want due to moderate pain in my neck
E. I can't read as much as I want due to severe pain in my neck
F. I can't read at all

SECTION 5 - *Headaches*

A. I have no headaches at all
B. I have slight headaches which comes infrequently
C. I have moderate headaches which come infrequently
D. I have moderate headaches which come frequently
E. I have severe headaches which come frequently
F. I have headaches almost all the time

SECTION 6 – *Concentration*

A. I can concentrate fully when I want to with no difficulty
B. I can concentrate fully when I want to with slight difficulty
C. I have a fair degree of difficulty concentrating when I want to
D. I have a lot of difficulty concentrating when I want to
E. I have a great deal of difficulty concentrating when I want to
F. I cannot concentrate at all

SECTION 7 – *Work*

A. I can do as much work as I want to
B. I can only do my usual work, but no more
C. I can do most of my usual work, but no more
D. I cannot do my usual work
E. I can hardly do any work at all
F. I cannot do any work at all

SECTION 8 – *Driving*

A. I can drive without any neck pain
B. I can drive as long as I want with slight pain in my neck
C. I can drive as long as I want with moderate pain in my neck
D. I cannot drive as long as I want due to moderate pain in my neck
E. I can hardly drive at all due to severe pain in my neck
F. I cannot drive my car at all

SECTION 9 – *Sleeping*

A. I have no trouble sleeping
B. My sleep is slightly disturbed (less than 1 hour sleepless)
C. My sleep is mildly disturbed (1-2 hours sleepless)
D. My sleep is moderately disturbed (2-3 hours sleepless)
E. My sleep is greatly disturbed (3-5 hours sleepless)
F. My sleep is completely disturbed (5-7 hours sleepless)

SECTION 10 – *Recreation*

A. I am able to engage in all my recreational activities with no neck pain at all
B. I am able to engage in all my recreational activities with some pain in my neck
C. I am able to engage in most, but not all of my recreational activities due to pain in my neck
D. I am able to engage in a few of my recreational activities due to pain in my neck
E. I can hardly do any recreational activities due to pain in my neck
F. I cannot do any recreational activities at all

COMMENTS: ______________________________

____

____

Name: ______________________________

Date: ____________________ Score: ________% *(Office Use Only)*

REVISED OSWESTRY PAIN DISABILITY QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much of your pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.*

SECTION 1 – *Pain Intensity*

A. The pain comes and goes and is very mild
B. The pain is mild and does not vary much
C. The pain comes and goes and is moderate
D. The pain is moderate and does not vary much
E. The pain comes and goes and is severe
F. The pain is severe and does not vary much

SECTION 2 – *Personal Care*

A. I don't have to change my way of washing/ dressing to avoid pain.
B. I don't normally change my way of washing or dressing even though it causes some pain
C. Washing and dressing increases pain, but I manage not to change my way of doing it
D. Washing and dressing increases pain and I find it necessary to change my way of doing it
E. Due to pain, I am unable to do some washing and dressing without help
F. Due to pain, I am unable to do any washing or dressing without help

SECTION 3 – *Lifting*

A. I can lift heavy weights without extra pain
B. I can lift heavy weights, but it causes extra pain
C. Pain prevents me lifting heavy weights off the floor
D. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned
E. Pain prevents me lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
F. I can only lift very light weights, at the most

SECTION 4 – *Walking*

A. Pain does not prevent me from walking any distance
B. Pain prevents me from walking more than one mile
C. Pain prevents me from walking more than ½ mile
D. Pain prevents me from walking more than ¼ mile
E. I can only walk while using a cane or on crutches
F. I am in bed most of the time & have to crawl to the toilet

SECTION 5 - *Sitting*

A. I can sit in any chair as long as I like without pain
B. I can only sit in my favorite chair as long as I like
C. Pain prevents me from sitting more than 1 hour
D. Pain prevents me from sitting more than ½ hour
E. Pain prevents me from sitting more than ten minutes
F. Pain prevents me from sitting at all

SECTION 6 – *Standing*

A. I can stand as long as I want without pain
B. I have some pain standing, but it doesn't increase with time
C. I can't stand longer than 1 hour without increasing pain
D. I can't stand longer than ½ hour without increasing pain
E. I can't stand longer than ten minutes without increasing pain
F. I avoid standing because it increases the pain

SECTION 7 – *Sleeping*

A. I get no pain in bed
B. I get pain in bed, but not preventing me from sleeping well
C. Due to pain, my normal night's sleep is reduced by less than one quarter
D. Due to pain, my sleep is reduced by less than one half
E. Due to pain, my normal night's sleep is reduced by less than three quarters
F. Pain prevents me from sleeping at all

SECTION 8 – *Social Life*

A. My social life is normal and gives me no pain
B. My social life is normal, but with increased pain
C. Pain has no effect on my social life apart from limiting my energetic interests (e.g. dancing, etc.)
D. Pain restricted my social life and I don't go out much
E. Pain has restricted my social life to my home
F. I have hardly any social life due to pain

SECTION 9 – *Traveling*

A. I have no pain while traveling
B. I have some pain while traveling
C. Extra pain with traveling, but I don't seek another form of travel
D. Extra pain while traveling makes me seek another form of travel
E. Pain restricts all forms of travel
F. Pain prevents all travel except that done lying down

SECTION 10 – *Changing Degree of Pain*

A. My pain is rapidly getting better
B. My pain fluctuates, but is getting better
C. My pain seems to be getting better slowly
D. My pain is neither getting better or worse
E. My pain is gradually worsening
F. My pain is rapidly worsening

COMMENTS: ______________________________

____
____
____

Name: ____

Date: ____________________ Score: ________% *(Office Use Only)*

CLINIC POLICIES

Thank you for choosing Siegenthaler Center as your healthcare provider. We are committed to the success of your treatment. The following are statements of our Policies which we require you read and sign prior to any treatment.

All patients must complete our Patient Information, Health Information, Policy and Coverage forms before seeing the doctor.

Full payment is due at time of service unless other arrangements are made. We accept cash, checks, credit and debit cards. We offer an extended payment plan where necessary and a Financial Agreement is signed.

REGARDING INSURANCE

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. In cases where benefits are not assignable or in any case where your benefit is processed to you, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from Siegenthaler Center is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically transferred to your credit card or the extended payment plan.
NOTE: Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance program. Specifically, most insurance plans do not provide coverage for maintenance or palliative care. If you are unsure as to the nature of the treatment you are receiving, please ask your doctor.

REGARDING DEDUCTIBLE AND CO-INSURANCE/CO-PAYMENT OBLIGATIONS

By law we are required to make reasonable efforts to collect deductibles and co-insurance and/or co-payment obligations. All co-insurance and/or co-payments and deductibles are required to be paid under the terms of your contract with your insurance carrier. By law we are responsible to attempt collections of these amounts once they are identified to us on your explanation of benefits. It is the policy of this clinic to bill for all co-insurance, co-payment and deductible amounts. If you have difficulty meeting your full responsibility under the terms of your insurance contract, please contact a member of our billing staff so that financial arrangements for payment can be made.

USUAL AND CUSTOMARY FEES

Our practice is committed to providing the best treatment for our patient and we charge what is suual and customary for our area. Our fees are generally considered to fall within the acceptable range by most companies, and the charge for each service is determined based on the relative value (RVU) of the service as published by the Center for Medicare/Medicaid Services (CMS) formerly known as HCFA. Not all carriers utilize CMS RVU's when determining their allowances for a service. Many carriers implement an arbitrary schedule of allowances. This clinic will accept your carrier's allowance as your payment as full provided that you meet any co-insurance, co-payment and/or deductible obligation assigned by your carrier within 60 days of the date of the EOB. This statement does mean that we accept the carrier's payment as payment in full. Your carrier generally only pays a portion or percentage of the allowed fee for a particular service in accordance with the terms of your benefit plan. Deductible, co-insurance and/or co-payment amounts are your responsibility.

NON-COVERED SERVICES

Your treatment may involve services that are not covered under your health benefit plan. You have the right to deny receipt of these services. If you elect to receive any or all services recommended, you will be fully responsible for payment of these services. We make every attempt to verify the limitation of your health insurance plan. As the information we receive is not a guarantee of coverage or benefits, we cannot be responsible for the validity of the information supplied to us by your carrier. You are responsible to verify your coverage limitation based on your benefit contract.

ADULT PATIENT

Adult patients are responsible for full payment at time of service unless we are accepting assignment from insurance. In this case, we recommend that you make some payment toward your obligation each visit. As detailed above you agree to be responsible for all co-insurance, co-payment, deductible and non-covered services as determined by your insurance carrier. For patients without insurance coverage, you agree to be responsible in full for all services provided in accordance with our negotiated fee schedule. In order to avoid fees for production of statements in the event we have to bill you for unpaid balances, we offer the option of billing your remaining balance to your credit card provided that you provide necessary information and authorization for credit card billing.

MINOR PATIENTS

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless patient responsibility has been pre-authorized to an approved credit plan, Visa/MasterCard, or payment by check or cash at time of service has been verified in advance of treatment.

Permission is hereby given by the undersigned to the Doctor(s) of Siegenthaler Center and whomever they designate to treat the minor patient. I certify by my signature below that I am the minor patient's legal guardian.

MISSED APPOINTMENTS

Please help us serve you better by keeping scheduled appointments. Further, understand that non-compliance with your ordered treatment plan may negate our ability to represent your services as medically necessary to your insurance carrier. **This is to remind you that in order for the services performed in this clinic to be billed to your insurance carrier, those services must be considered to be medically necessary.** Part of satisfying the medical necessity requirements is for this clinic to develop a treatment program that is oriented toward improving your level of functionality to your maximum potential. Our ability to assist you with meeting these goals is based on your commitment to your ordered treatment program. Non-compliance with your treatment plan will interfere with our ability to make the progress that is required by your carrier to establish the medical necessity of the services such that they become covered by your insurance plan. If you are non-compliant with your ordered treatment plan you will be discharged from that plan. If this is the case, you will be offered maintenance treatment on a schedule that you can determine. This type of treatment, however, is not generally a covered benefit under most insurance plans and this clinic will not bill these services to your carrier. The burden of payment for this type of treatment will be your responsibility.

FINANCIAL ARRANGEMENTS

Where necessary based on your financial circumstances, we will permit you to make payment arrangements that will permit you to meet the obligations detailed in your insurance benefit contract and this policy. Strict adherence to the financial arrangements you make is required. You must relay any changes you may require to your previously agreed financial arrangements to our financial department immediately. Past due balances that cannot be handled in house will be referred to outside collection agencies or to litigation for collection. When this is necessary, you agree to be additionally responsible for any costs and attorneys' fee related to the collection of unpaid amounts plus interest at the rate of ten percent (10%) per annum for each day payment is more than 30 days overdue.

I have read and agree to these clinic policies and authorize this clinic to bill my credit card as detailed above or where no credit card information is evident, agree to complete a financial agreement related to services received but not paid for in full by my health insurance benefit plan.

X ____ ____________________

Signature of Patient or Responsible Party/Guardian Date

X ____ ____________________

Signature of Staff Witness Date

RELEASE OF INFORMATION – HIPPA PRIVACY

This clinic is concerned about the privacy of your individually identifiable health information and has enacted policies and procedures to protect your privacy as required by the Health Insurance Portability and Accountability Act of 1996. A notice of this clinic's privacy practices is posted in the clinic or can be obtained from a staff member.

I acknowledge that I have received the Notice of Privacy Practices for protected health information.

Date: ________________________ Name of Patient: (printed) ____________________________

Signature of Patient/Personal Representative: ____________________________

CREDIT CARD RELEASE

If you would prefer to have your credit card on file for us to run each visit, please include the information below. You may pay each visit using cash, credit card or check. If you choose not to include your credit card information, you will be responsible for payment on the date of service by other means.

Credit Card Account to Bill for Deductible, Co-Insurance, Co-Payment or Non-Covered Services:

X ____ ________________ __________

Credit Card Number Expiration Date CVV Code

INFORMED CONSENT FOR CHIROPRACTIC CARE

Patient, in coming to Siegenthaler Center, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from; latent pathological defects, illnesses or deformities which would otherwise not come to the specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Siegenthaler Center, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient Signature: ____ Date: _____________