

Welcome to
Mars Hill Chiropractic Center

342 Carl Eller Road Mars Hill NC 28754
Telephone # (828) 689-3777
Fax # (828) 689-5435

Today's Date: _____

Full Name: _____

Name you prefer to be called: _____

Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Medical Doctor: _____

Practice Name: _____

(example: Mars Hill Medical Center)

Marital Status (circle): single married divorced widowed

Birthdate: _____ Age: _____

Referred by: _____

Work Status: _____

Employer: _____

Occupation: _____

of children: _____ Age(s): _____

Emergency Contact Person: _____

Emergency Contact #: _____

Relationship to you: _____

Is your pain or injury the result of an accident? YES NO

If yes, was it: auto accident injury accident at work

Please read and initial:

____ We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between doctor and patient.

____ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with our business manager. If account is not paid within 90 days of date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collection of your account.

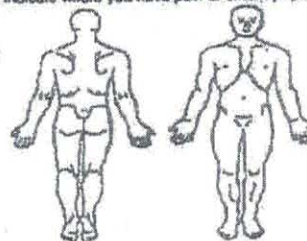
____ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status or any changes to the information I have provided on this form.

Signature: _____ Date: _____

Patient: _____ D.O.B. _____ Date: _____

1. Briefly Describe your **PRIMARY** complaint: _____

Indicate where you have pain or other symptoms.



2. Pain is: Sharp Dull Burning Throb Stabbing Numb Ache Other _____

3. When did your symptoms start? _____

4. How did your symptoms start? _____

5. Average pain intensity:

In the last 24 hours: no pain 1 2 3 4 5 6 7 8 9 10 worst pain

In the past week: no pain 1 2 3 4 5 6 7 8 9 10 worst pain

6. How often do you experience your symptoms?

Constantly (75-100% of the time) Frequently (50-75% of the time) Occasionally (25-50% of the time) Intermittently (0-25%)

7. How are your symptoms changing? Getting better Not changing Getting worse

8. What makes your symptoms better? _____

9. What makes your symptoms worse? _____

10. Have you had this problem examined by anyone else? _____

11. What have you done to treat this problem? _____

Additional complaints:

1. _____

2. _____

3. _____

Current Medications, including dosage if known. If there are no current medications, check here:

1) _____

5) _____

2) _____

6) _____

3) _____

7) _____

4) _____

8) _____

List any known allergies you have had to medications. If no allergies are known, check here:

1) _____

2) _____

Has your doctor diagnosed you with High Blood Pressure presently? Yes No If yes, describe: _____

Has your doctor diagnosed you with Diabetes presently? Yes No If yes, what kind? Type 1 Type 2

Have you had an X-ray, CT scan or MRI of your spine in the past 28 days? Yes No

MARS HILL CHIROPRACTIC CENTER

Functional Rating Index

For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain, no restrictions	Mild pain, no restrictions	Moderate pain, need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus additional work	Can do usual work	Can do 50% of usual work	Can do 25% of usual work	Cannot do any work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain, 25% of the day	Intermittent pain, 50% of the day	Frequent pain, 75% of the day	Constant pain, 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain, any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

PATIENT NAME _____

DATE _____

Patient Health Questionnaire

Patient Name _____

Date _____

What type of regular exercise do you perform? None Light Moderate Strenuous

What is your height & weight? Height _____ ft _____ in. Weight _____ lbs.

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	Past Present	Past Present
<input type="checkbox"/> <input type="checkbox"/> Headaches	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Diabetes
<input type="checkbox"/> <input type="checkbox"/> Neck Pain	<input type="checkbox"/> <input type="checkbox"/> Heart Attack	<input type="checkbox"/> <input type="checkbox"/> Excessive Thirst
<input type="checkbox"/> <input type="checkbox"/> Upper Back Pain	<input type="checkbox"/> <input type="checkbox"/> Chest Pains	<input type="checkbox"/> <input type="checkbox"/> Frequent Urination
<input type="checkbox"/> <input type="checkbox"/> Mid Back Pain	<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/> <input type="checkbox"/> Smoking/Use Tobacco Products
<input type="checkbox"/> <input type="checkbox"/> Low Back Pain	<input type="checkbox"/> <input type="checkbox"/> Angina	<input type="checkbox"/> <input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/> <input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> <input type="checkbox"/> Kidney Stones	<input type="checkbox"/> <input type="checkbox"/> Allergies
<input type="checkbox"/> <input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/> <input type="checkbox"/> Kidney Disorders	<input type="checkbox"/> <input type="checkbox"/> Depression
<input type="checkbox"/> <input type="checkbox"/> Wrist Pain	<input type="checkbox"/> <input type="checkbox"/> Bladder Infection	<input type="checkbox"/> <input type="checkbox"/> Systemic Lupus
<input type="checkbox"/> <input type="checkbox"/> Hand Pain	<input type="checkbox"/> <input type="checkbox"/> Painful Urination	<input type="checkbox"/> <input type="checkbox"/> Epilepsy
<input type="checkbox"/> <input type="checkbox"/> Hip/Upper Leg Pain	<input type="checkbox"/> <input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/> <input type="checkbox"/> Dermatitis/Eczema, rash
<input type="checkbox"/> <input type="checkbox"/> Knee/Lower Leg Pain	<input type="checkbox"/> <input type="checkbox"/> Prostate Problems	<input type="checkbox"/> <input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> <input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/> <input type="checkbox"/> Abnormal Weight Gain/Loss	Females Only
<input type="checkbox"/> <input type="checkbox"/> Jaw Pain	<input type="checkbox"/> <input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> <input type="checkbox"/> Prescription Birth Control
<input type="checkbox"/> <input type="checkbox"/> Joint Swelling/Stiffness	<input type="checkbox"/> <input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> <input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Ulcer	<input type="checkbox"/> <input type="checkbox"/> Pregnancy
<input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> <input type="checkbox"/> Hepatitis	Other Health Problems/Issues
<input type="checkbox"/> <input type="checkbox"/> General Fatigue	<input type="checkbox"/> <input type="checkbox"/> Liver/Gall Bladder Disorder	<input type="checkbox"/> <input type="checkbox"/> _____
<input type="checkbox"/> <input type="checkbox"/> Muscular Incoordination	<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> _____
<input type="checkbox"/> <input type="checkbox"/> Visual Disturbances	<input type="checkbox"/> <input type="checkbox"/> Tumor	<input type="checkbox"/> <input type="checkbox"/> _____
<input type="checkbox"/> <input type="checkbox"/> Dizziness	<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> _____
	<input type="checkbox"/> <input type="checkbox"/> Chronic Sinusitis	

Indicate if an immediate family member has had any of the following:
 Rheumatoid Arthritis Heart Problems Diabetes Cancer Lupus Other: _____

List all the surgical procedures you have had and any times you have been hospitalized:

Patient Signature: _____ Date: _____

**Mars Hill Chiropractic Center
Financial Agreements**

The best attention can be given to you and your health concerns when we know that you expect of us, and you know what we expect of you.

Ultimately **YOU** are responsible for all charges at this office, not your insurance company. It is your responsibility to communicate with your insurance company. We will help whenever possible.

If it appears that you have insurance which will cover a portion of your charges at this office, and they deny coverage, the balance will be your responsibility.

Upon completion of treatment for a particular condition, many people continue on with preventative/maintenance chiropractic care with very satisfying results. However, since your insurance company will not cover maintenance services, we will offer you a cash discount, if paid at time of services. We do not file maintenance visits with your insurance company.

Below is a fee schedule that lists many of the common services at this office.

Initial exam	\$98.00	X-rays per region	\$50.00
Reexam	\$50.00	Manual therapy (muscle treatment)	\$14.00
Adjustment of 1-2 regions	\$38.00	Kinesiology testing	\$14.00
Adjustment 3-4 regions	\$49.00	Intersegmental traction	\$14.00
Urinalysis	\$10.00	Wellness adjustment	\$38.00
Interferential current	\$14.00	(paid at time of service)	

There will be a \$25.00 fee for any returned checks.

Past due accounts are subject to a 10% per month billing charge.

I have read and accept the above financial agreements.

Signature of Patient: _____ **Date:** _____

Or signature of Parent or Guardian: _____ **Date:** _____

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which Mars Hill Chiropractic Center may have to use or disclose your health care information. We may have to disclose your health information

- to another health care provider for referral to them for treatment or diagnosis
- to an insurance company or another party if they are responsible for payment of your services for treatment
- amongst the staff within our practice for quality control or administrative purposes.

Your right to limit uses or disclosures

I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Mars Hill Chiropractic Center will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Mars Hill Chiropractic Center's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice at any time.

Signature: _____

Date: _____

Printed Name: _____

INFORMED CONSENT TO CHIROPRACTIC CARE

We provide adjustments or manual manipulations through the gentle application of a targeted movement where and when indicated by a licensed Doctor of Chiropractic to improve motion of the body's spinal column and extremities.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches, and other similar symptoms. Routine chiropractic treatment can result in better function, improved joint motion, and a healthier, more active lifestyle.

However, there are some risks associated with the chiropractic adjustments, including, but not limited to the possibility of sprains, dislocations, and fractures. In addition:

1. While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques.
2. There are reported cases of stroke associated with neck movements including adjustments of the upper cervical spine. Current medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because a stroke may cause serious neurological impairment and result in injuries including paralysis.
3. There are reported cases of disc injuries following a cervical and lumbar spinal adjustments or chiropractic treatment.

The risk of injuries or complications from chiropractic treatments are substantially lower than that associated with many medical or other treatments, medications, and surgical procedures given for the same treatments.

Common alternatives to adjustments and manipulations include medications, physical therapy, or medical treatments and surgery provided by physicians and surgeons.

By signing this informed consent, I acknowledge that I have discussed, or have had the opportunity to discuss, with my Doctor of Chiropractic the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustments), the benefits, risks and alternatives to chiropractic treatment.

I consent to the chiropractic treatments offered or recommended to me by my Doctor of Chiropractic, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care received from Mars Hill Chiropractic Center.

Patient Printed Name _____

Patient Signature _____

Legal Guardian Signature _____

Date _____ Witness Signature _____

Mars Hill Chiropractic Center
342 Carl Eller Rd, Mars Hill, NC 28754
828-689-3777

Patient Name:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for services 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 services below.

Services	Reason Medicare May Not Pay:	Estimated Cost
Spinal Manipulation	Medicare may construe your spinal manipulation to be maintenance care which is not a medically necessary service.	\$38 for Maintenance Manipulation
X Ray	This is not a covered service under Medicare.	\$50
Examination	This is not a covered service under Medicare.	1st Exam : \$81 to \$98 Re-Exam : \$50 to \$63
Therapy	This is not a covered service under Medicare.	\$14
Vitamins, Supplements, Pillows, Ice Packs, Ointments, Braces, Supports	This is not a covered service under Medicare.	Prices as marked on product

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 services 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.

OPTIONS:	Check only one box. We cannot choose a box for you.
<input type="checkbox"/>	OPTION 1. I want the services 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.
<input type="checkbox"/>	OPTION 2. I want the services 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.
<input type="checkbox"/>	OPTION 3. I don't want the services listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

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.

Signature:	Date:
-------------------	--------------

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA