

Ultimate Spine & Wellness

Account Number: _____

Date: _____

Name: _____

Birthdate: _____

Address: _____

Sex: Male Female

City: _____

Social Security No.: _____

State: _____ Zip Code: _____

Marital Status: Married Single Divorced Widowed

Primary Phone: _____

Spouse Name: _____

Do you wish to receive text appt alerts

Name of Emergency Contact: _____

Cell Phone: _____

Primary Care Physician: _____

Cell Service Provider: _____

Race: White A. American Asian American Indian

Email: _____

Ethnicity: Hispanic Non- Hispanic

Employer: _____

Preferred Language: _____

How did you hear about us?

Insurance:

Insurance Co.: _____

Subscribers Name: _____

Insured: Check One: Self Spouse Parent Other: _____

Birthdate: _____ Subscriber No.: _____ Group#: _____

Effective Date: _____ Deductible: _____

Is patient covered by additional insurance? Yes No Date: _____

Accident Information:

Is condition due to an accident? Yes No Date: _____

Type of accident: Auto Work Home Other: _____

If Disabled From Work Please Give Dates: _____

Attorney Name (If applicable): _____

Attorney Address and Phone Number (If applicable): _____

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications. The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare". **Other treatment options which could be considered may include the following:**

- Over-the-counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects.
- Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics.
- Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

AUDIO / VIDEO CONSENT YES NO

I hereby give permission to Ultimate Spine & Wellness to use my image, likeness, and voice as recorded on audio or video without payment or any other consideration. In addition, I give permission to discuss my case and outcomes with anonymity (all names, ages and genders will be changed).

By signing this release, I understand this permission signifies that photographic or video recordings of me may be electronically displayed and posted on a website, published in print, used in documentary video, or shown in the public or private educational setting. My case may be discussed on the Ultimate Spine & Wellness blog, YouTube channel or in office lectures/presentations.

Printed Name (If Minor please indicate parent name)

Signature

Date

Ultimate Spine and Wellness

Name: _____

Date: _____

Chief Complaint – List current problems:

PAIN 1 – NO PAIN
LEVEL 10 – WORSE PAIN EVER

Please mark area & type of pain on the drawing

1. _____ / 10 **HOW LONG:** _____

INTENSITY: Minimum Mild Moderate Severe

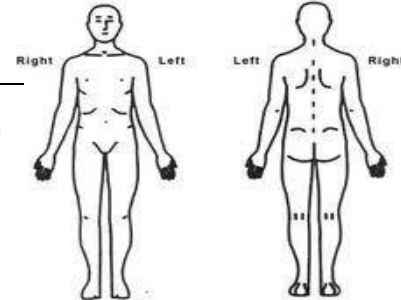
QUALITY OF PAIN: Burning Aching Numb Radiating Sharp Shooting Stabbing Tight Throbbing

WHAT MAKES IT BETTER? Nothing Chiropractic Heat Ice Massage Pain meds Sleep/Rest

PRESENT: 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

WHAT MAKES IT WORSE? Sitting Standing Walking Bending Exercise

N- Numbness
T- Tingling
P- Pain
S- Stiffness



2. _____ / 10 **HOW LONG:** _____

INTENSITY: Minimum Mild Moderate Severe

QUALITY OF PAIN: Burning Aching Numb Radiating Sharp Shooting Stabbing Tight Throbbing

WHAT MAKES IT BETTER? Nothing Chiropractic Heat Ice Massage Pain meds Sleep/Rest

PRESENT: 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

WHAT MAKES IT WORSE? Sitting Standing Walking Bending Exercise

MEDICAL HISTORY: Please check all the following that apply to you:

<input type="checkbox"/> NONE <input type="checkbox"/> Back Pain <input type="checkbox"/> Neck Pain <input type="checkbox"/> Jaw Pain / TMJ <input type="checkbox"/> Chest Pain <input type="checkbox"/> Hip Pain <input type="checkbox"/> Knee Pain <input type="checkbox"/> Foot Pain <input type="checkbox"/> Arm Pain <input type="checkbox"/> Shoulder Pain <input type="checkbox"/> Hand Pain <input type="checkbox"/> Pain w/Cough/Sneeze <input type="checkbox"/> Numbness <input type="checkbox"/> Dizziness <input type="checkbox"/> Headaches <input type="checkbox"/> Herniated Disc <input type="checkbox"/> Poor Posture <input type="checkbox"/> Scoliosis <input type="checkbox"/> Swollen Joints	<input type="checkbox"/> ADHD <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Alcohol/Drug depend <input type="checkbox"/> Allergies <input type="checkbox"/> Anemia <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Anxiety <input type="checkbox"/> Arteriosclerosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Autism <input type="checkbox"/> Bakers cyst <input type="checkbox"/> Barretts esophagus <input type="checkbox"/> Bipolar <input type="checkbox"/> Cancer / Tumor <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy / Seizures	<input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Gastritis <input type="checkbox"/> GERD <input type="checkbox"/> Gout <input type="checkbox"/> Hearing Problems <input type="checkbox"/> Heart Problems <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Irritable Bowl <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Loss of Memory <input type="checkbox"/> Loss of Balance <input type="checkbox"/> Lupus <input type="checkbox"/> Menstrual Problems <input type="checkbox"/> Mood changes <input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Parkinson's <input type="checkbox"/> Prostate problems <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Sinus Infection <input type="checkbox"/> Sleep disturbance <input type="checkbox"/> Osteopenia <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Pacemaker <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Spinal cord injury <input type="checkbox"/> Spinal stenosis <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid -- Hypo <input type="checkbox"/> Thyroid -- Hyper <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcers <input type="checkbox"/> Varicose Veins
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ALLERGIES: None Penicillin Aspirin Codeine Sulfa Other: _____

PREVIOUS SURGERIES: None : _____

CURRENT MEDICATIONS: _____

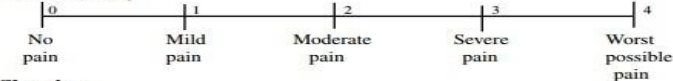
FAMILY HISTORY: Cancer Mother / Father / Child / Sibling Diabetes Mother / Father / Child / Sibling

Heart Problems Mother / Father / Child / Sibling High Blood Pressure Mother / Father / Child / Sibling

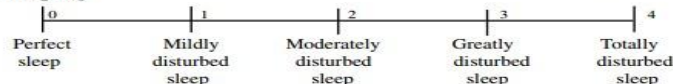
PAST INJURIES: Auto _____ Sports _____ Other _____

SOCIAL HISTORY: Alcohol _____ Smoking _____ Recreational Drugs _____

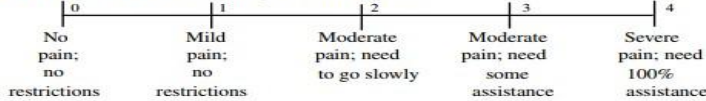
1. Pain Intensity



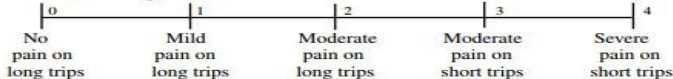
2. Sleeping



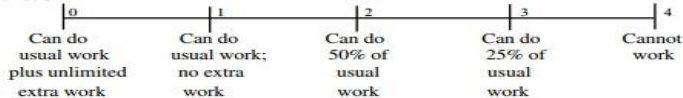
3. Personal Care (washing, dressing, etc.)



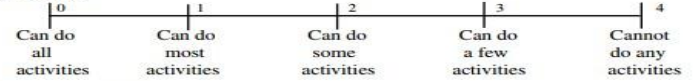
4. Travel (driving, etc.)



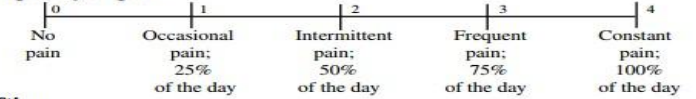
5. Work



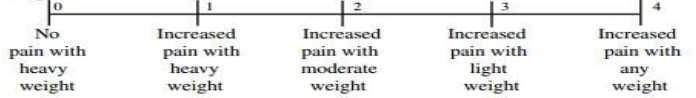
6. Recreation



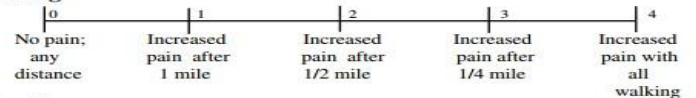
7. Frequency of pain



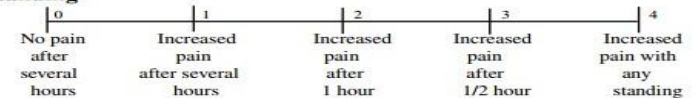
8. Lifting



9. Walking



10. Standing



PATIENT SIGNATURE: _____

DATE: _____

Ultimate Spine & Wellness

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 1251 S Volusia Ave
 Orange City, FL 32763
 Phone: 386-668-6321
 Fax: 386-775-1452

OFFICE FEE SCHEDULE

<u>Billed Services</u>		<u>Non-Covered Services</u>		<u>Supplies</u>	
Initial Visit and Exam	\$130	Medicare Initial Visit and Exam	\$35	Hot / Cold Pack	\$35
Re -Activation Exam	\$100	Medicare Re-Exam	\$25	Muscle Relaxer Formula 303	\$20
Re - Exam	\$70	Initial Medical Nutrition Assess.	\$70	Cryoderm	\$20
Manipulation 1-2	\$60	Follow Up Nutrition Assessment	\$35	Ciroflow Water Pillow	\$60
Manipulation 3-4	\$85	Infrared / Laser	\$35	Cervical Pillow	\$50
Manipulation 5	\$115	Kinesiology Tape	\$7	Home Traction Cervical	\$45
Manipulation of Extremity	\$60	Cupping Therapy	\$45	Calming Magnesium Cream	\$28
Electrical Stimulation	\$76	Decompression Therapy	\$200	MCHC	\$18
Massage Therapy 15 mins	\$20	School Physical	\$25	Turmeric	\$40
Massage Therapy 30 mins	\$40	X-Ray Cervical - 3 views	\$225	Support Adrenals	\$40
Massage Therapy 60 mins	\$75	X-Ray Thoracic	\$250	BioActive Nutritional	\$14
Manual Therapy	\$119	X-Ray Lumbar - 3 Views	\$250	CW Oil	\$60
Ultrasound Therapy 15 Mins	\$25...	X-Ray Extremities	\$150	TrueEase	\$89
Other: _____		Additional X-Ray View	\$100	Nano Greens	\$40
Other: _____		Other: _____		Vitamin Med Weight Loss	\$200

OFFICE FINANCIAL POLICY

CASH

We accept cash, check, Visa, Master Card, Discover and American Express.

INSURANCE

As a courtesy we will bill your insurance company for you. All co-pay amounts and deductibles are due at the time of service. We encourage you to call your insurance company to confirm your coverage percentage and limits. Knowing your insurance benefits is your responsibility. We will call your insurance company to verify coverage. What we are told on the phone is not always the same as what they end up paying. You are responsible for any difference between the billed allowable amount and what we receive from your insurance company.

MEDICARE

I am a Medicare provider. Medicare covers the chiropractic adjustment at 80%. Most supplemental plans pay the remaining 20%. Medicare and the supplement do not cover the initial exam, re-exams and x-ray fee, this is the patient's responsibility.

AUTO ACCIDENT INSURANCE (PIP)

Your auto insurance covers your injuries at 100% up to the limits of your policy. Some policies cover 80%. The remaining 20% will be collected from the patient.

WORKERS' COMP

Work related injuries must be pre-approved by your employer and insurance carrier. Most new cases need a referral from the PCP.

CANCELLATIONS

We do not double book. Your appointment time is reserved for you. We appreciate a 24-hour notice on all canceled appointments. We reserve the right to charge you \$20 for all missed appointments.

Patient Signature: _____

Date: _____