



DR. LAURA E. HARRINGTON
 Liverpool Chiropractic & Wellness, PLLC

403 Tulip Street
 Liverpool, New York 13088
 Telephone: (315) 461-4510

Questionnaire (Confidential)

Date: _____

Client Name: _____ Called Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Pager Number: _____

Email Address: _____ Sex: M F

Check Box: Minor Single Married Domestic Partner Separated Divorced Widowed

Birthdate: _____ Age: _____ Social Security #: _____

Are you here because of a: **Work related injury?** Yes No **Auto accident?** Yes No

How did you hear about our office? Referral, by whom? _____
 Office Sign Yellow Pages Newspaper
 Other (please specify) _____

Primary M.D.: _____ Phone: _____

May we contact you Primary M.D. regarding your care in this office? Yes No

Occupation: _____
 (Describe activities involved – sitting, standing, lifting)

Employer Name: _____

Address: _____

City: _____ State: _____ Zip: _____

May we contact you at work, if necessary? Yes No

Person to contact in case of emergency: _____ Phone #: _____

I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance, Medicare, Worker's Compensation, and No-Fault (auto accidents). I also authorize payment of insurance benefits otherwise payable to me directly to the doctor. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all my insurance submissions.

I certify that I have read and understand the following information. To the best of my knowledge the following questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X _____
 Signature of client (or parent if minor)

 Date



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Informed Consent for Chiropractic Care

When a client seeks chiropractic health care and we accept a client for such care, it is essential for both to be working for the same objective. Chiropractic has only one goal. It is important that each client understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is the science, philosophy, and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance of the nervous system is called a vertebral subluxation. This is a misalignment of one of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments may be performed by hand or instrument where the doctor will put pressure on a specific segment(s) of the spine to adjust the vertebra into a better position.

We only offer to diagnosis either vertebral subluxations or neuro-musculoskeletal conditions. During the course of a chiropractic spinal examination, if we encounter non-chiropractic or unusual findings, we will advise you and recommend that you seek the services of another health care provider for further testing.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

Chiropractic care has been proven to be very safe and effective. It is not unusual however to be sore after your first few corrective adjustments. Although rare, it is possible to suffer from other side effects; i.e. muscle spasms, stiffness, headache, dizziness, rib fracture, and stroke.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and accept chiropractic care on this basis. _____ *Initial*

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have read, reviewed, understand and agree to the Notice of Privacy Practices, which describes the practice's policies and procedures regarding the use or disclosure of my protected health information created, received or maintained by the practice. _____ *Initial*

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle _____.

 Print Name

 Signature of Client or Responsible Party

 Date



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Financial Policies

Thank you for choosing Liverpool Chiropractic as part of your healthcare team. We look forward to serving the needs of you and your family. We are committed to providing you with quality and affordable health care. We believe in informing our patients, from the beginning, about their financial responsibilities for services rendered to prevent any confusion. A copy will be provided to you upon request.

- Until insurance coverage and deductible is verified by our staff, all clients are on a private pay basis and payment in full is expected at each visit.
- This office may make payment plans on an individual basis. Any such plan or arrangement will be discussed after the final Report of Findings and treatment recommendations.

If you have insurance, we will gladly take assignment in most cases, provided we have prior authorization from your insurance company. **While we have taken efforts to verify your insurance, this is not a guarantee of benefits.** There are additional guidelines that apply to patients of Medicare or other federally reimbursed programs.

- We accept assignment as a courtesy to you. You are responsible for your entire bill should your insurance company not pay any anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute, as your contract is between you and your insurance company. Knowing your insurance benefits is your responsibility. If a referral is required, it is your responsibility to make sure that it is in place prior to visiting our office.
- Services performed do not constitute a guarantee of payment by your insurance company. Any services not covered or coverage reductions by your insurance company will be your responsibility. Every insurance company is different and payments as well as denials are subject to your individual policy.
- **If an insurance carrier denies a claim due to “medical necessity”, you are responsible for payment of that claim.** We feel that every adjustment we provide is medically necessary and we realize that we have no control over what any insurance carrier defines as medically necessary.
- Payments made by your insurance company directly to you for services rendered in this office should be returned to this office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue an over-payment check.
- If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjustor or agent. We will not enter into any dispute with your insurance company. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges in a timely fashion.
- Changes in your insurance are to be reported to this office as soon as possible to prevent delays in billing. If this information is not received by our office and your claim is denied, you will be responsible for the entire bill.
- In the event that your insurance company deniers your claim, we will bill you directly for the balance. There is a 1.5% per month interest charge on all past due accounts. If your account is over 90 days past due, you will receive a letter stating that you need to pay your account in full. Partial payments will not be accepted unless otherwise negotiated with the doctor. Please be aware that if a balance remains unpaid, we will refer your account to collections and service fees will be applied as well.

Our practice is committed to providing exceptional chiropractic care to our clients. Our prices are representative of the usual and customary charges for our area.

Thank you for reading and understanding our financial policy. Please let us know if you have any questions or concerns. We are here to help!

I have read and understand the Financial Policies above and agree to abide by these terms.

Signature of Client or Responsible Party

Date

Health Questionnaire

Client Name: _____

Date: _____

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="radio"/> <input type="radio"/> Back feels out of place	<input type="radio"/> <input type="radio"/> Chronic sinusitis	<input type="radio"/> <input type="radio"/> Urinary difficulty
<input type="radio"/> <input type="radio"/> Back Stiffness	<input type="radio"/> <input type="radio"/> Digestive problems	<input type="radio"/> <input type="radio"/> Varicose veins
<input type="radio"/> <input type="radio"/> Back weakness	<input type="radio"/> <input type="radio"/> Hemorrhoids	<input type="radio"/> <input type="radio"/> Vascular problems
<input type="radio"/> <input type="radio"/> Grinding/popping sounds	<input type="radio"/> <input type="radio"/> Poor circulation	<input type="radio"/> <input type="radio"/> Vomiting/Vomiting blood
<input type="radio"/> <input type="radio"/> Herniated disc	<input type="radio"/> <input type="radio"/> Anemia/Bruise easily	<input type="radio"/> <input type="radio"/> Weight change
<input type="radio"/> <input type="radio"/> Leg cramps	<input type="radio"/> <input type="radio"/> Asthma	Smoking history
<input type="radio"/> <input type="radio"/> Muscle spasms	<input type="radio"/> <input type="radio"/> Bleeding Disorders	How much/long? _____
<input type="radio"/> <input type="radio"/> Numbness	<input type="radio"/> <input type="radio"/> Dental problems	Men only
<input type="radio"/> <input type="radio"/> Pain from front to back	<input type="radio"/> <input type="radio"/> Difficulty swallowing	<input type="radio"/> <input type="radio"/> Erectile difficulties
<input type="radio"/> <input type="radio"/> Pinched nerve	<input type="radio"/> <input type="radio"/> Fatigue	Women only
<input type="radio"/> <input type="radio"/> Pins & needles	<input type="radio"/> <input type="radio"/> Fever	<input type="radio"/> <input type="radio"/> Extreme menstrual pain
<input type="radio"/> <input type="radio"/> Tension in back	<input type="radio"/> <input type="radio"/> Fractures	<input type="radio"/> <input type="radio"/> Hot flashes
<input type="radio"/> <input type="radio"/> Weakness	<input type="radio"/> <input type="radio"/> Hearing loss or Ringing	<input type="radio"/> <input type="radio"/> Miscarriage
<input type="radio"/> <input type="radio"/> Pain between shoulder blades	<input type="radio"/> <input type="radio"/> High/low blood pressure	<input type="radio"/> <input type="radio"/> Painful intercourse
<input type="radio"/> <input type="radio"/> Pain in shoulder joint	<input type="radio"/> <input type="radio"/> Hoarseness	<input type="radio"/> <input type="radio"/> Other
<input type="radio"/> <input type="radio"/> Pain across shoulders	<input type="radio"/> <input type="radio"/> Mononucleosis	Method of birth control _____
<input type="radio"/> <input type="radio"/> Can't raise arm	<input type="radio"/> <input type="radio"/> Multiple sclerosis	_____
<input type="checkbox"/> Above shoulder level	<input type="radio"/> <input type="radio"/> Osteoporosis	Are you nursing? Y/ N
<input type="checkbox"/> Over head	<input type="radio"/> <input type="radio"/> Pacemaker	Number of children _____
<input type="radio"/> <input type="radio"/> Migraines/Headaches	<input type="radio"/> <input type="radio"/> Persistent cough	Have you ever taken birth control
<input type="radio"/> <input type="radio"/> Nausea/Vomiting	<input type="radio"/> <input type="radio"/> Polio	pills? _____
<input type="radio"/> <input type="radio"/> Bloating/Gas	<input type="radio"/> <input type="radio"/> Psychiatric care	When? _____
<input type="radio"/> <input type="radio"/> Constipation/Diarrhea	<input type="radio"/> <input type="radio"/> Sweats	

Please indicate if YOU or any of your immediate family has or had any of the following:

- Cancer Thyroid Problems Rheumatoid Arthritis Heart Problems/Stroke Diabetes Lupus

List any vitamins you are currently taking: _____

List any other allergies: _____

List all surgical procedures and hospitalizations: _____

When did you last see a chiropractor? _____ Dr: _____

Why did you see this chiropractor? _____ Were you helped? _____

What spinal maintenance programs were you given to follow to maximize the future stability of you spine? _____

Did you follow it? _____ If not, why? _____

Why are you changing chiropractors? _____

Why did you come into our clinic and what are your expectations of us? _____

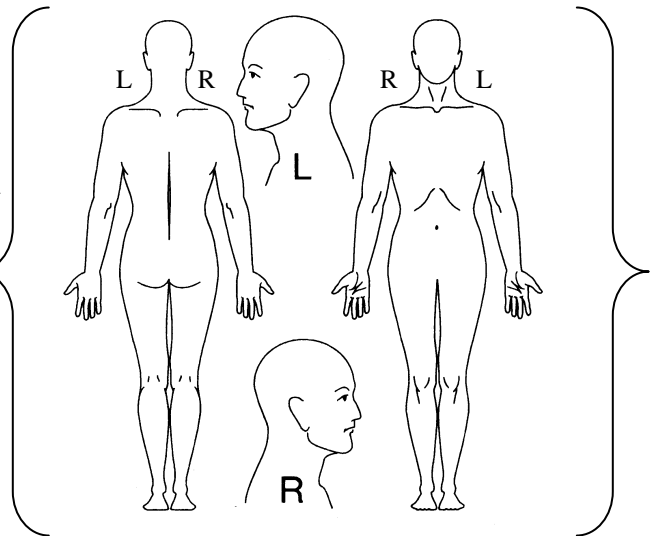
What is your health philosophy? (What should you do to be healthy?) _____

Client Name: _____

Date: _____

Please use the following descriptive symbols on the body to the right to describe the location of your problem.

Aching ^^^^	Burning =====	Pins & Needles -----
Numberness 000000	Stabbing ////////	Other XXXXXX
		XXXXXX



What type of regular exercise do you perform?

- None Light Moderate Strenuous

What is your height and weight?

Height _____ Weight _____ Shoe Size _____

When/How did your symptoms start? _____

What are your symptoms? _____

Have you had similar symptoms in the past? _____

How often do you experience these symptoms?

- Constantly (76%-100%) Frequently (51%-75%) Occasionally (26-50%) Intermittently (<25%)

How would you describe your symptoms?

- Sharp Dull Numb Shooting Burning Tingling

Please circle the level of pain on this scale at its worst: None 1 2 3 4 5 6 7 8 9 10 Worst Possible

Please circle the level of pain on this scale at its best: None 1 2 3 4 5 6 7 8 9 10 Worst Possible

How are your symptoms changing? Getting Worse Not Changing Getting Better

On a scale of 1-10 (10 being the most, and 1 being the least),

_____ **How committed are you at being at your maximum health potential?**

_____ **How important is it for your family to be at their optimal health potential?**

_____ **How committed are you to preventing arthritis and maximizing your spinal stability?**

Most clients that come to our office have one of two objectives in mind concerning their health care. Some clients come for symptomatic relief of pain or discomfort (**Relief Care**). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (**Corrective Care**). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

- Relief Care** (Help the symptom but do not fix the cause of the problem)
- Corrective Care** (Correct the cause of the problem for maximum stability in the future)
- Check here if you want the Doctor to select the type of care appropriate for your condition

X _____
Signature of client (or parent if minor)

Date



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Client Name: _____

Date: _____

If you are using Medical Insurance to help pay for care, please fill out the insurance questionnaire below.

Insurance Questionnaire (Confidential)

Primary Insurance Company Name: _____

Subscriber ID Number: _____ Group Number: _____

Primary Insured Name: _____

Address (If different): _____

City: _____ State: _____ Zip: _____

Primary Insured's Employer Name: _____

Primary Insured Birthdate: _____ Sex: M F

Relation: Self Spouse Child Other / Domestic Partner

If you have secondary insurance, please complete the following:

Secondary Insurance Company Name: _____

Subscriber ID Number: _____ Group Number: _____

Secondary Insured Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Secondary Insured's Employer Name: _____

Secondary Insured Birthdate: _____ Sex: M F

Relation: Self Spouse Child Other / Domestic Partner

If you have tertiary (3rd) insurance, please complete the following:

Tertiary Insurance Company Name: _____

Subscriber ID Number: _____ Group Number: _____

Tertiary Insured Name: _____

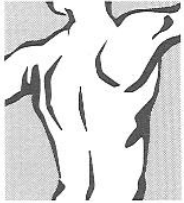
Address: _____

City: _____ State: _____ Zip: _____

Tertiary Insured's Employer Name: _____

Tertiary Insured Birthdate: _____ Sex: M F

Relation: Self Spouse Child Other / Domestic Partner



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Electronic Health Records Intake Form

In compliance with Medicare requirements for the government EHR incentive program

First Name: _____ **Last Name:** _____

Preferred method of communication for client reminders (Circle one): Email / Phone / Mail

Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
 Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

I choose to receive a receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Client Signature: _____ Date: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____ / _____