DeLand Chiropractic & Spinal Decompression

New Patient Application

The information that you will provide on this form will play a key role in determining your ability to be accepted as a patient in this office. your qualification as a patient is determined by the nature of your injury, the doctor's ability to treat your condition, your commitment to getting well, your family and/or spousal support, your ability to pay for recommended care, and your willingness to make sacrifices to ensure your proper healing. Please be sure that you answer all questions. Thank you - Dr. Gordon's Staff.

Name: _____ Sex: M / F Marital Status: S M D W
Address: _____ City: _____
State: _____ Zip Code: _____ Date of Birth: _____ SSN: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Employer: _____ Occupation: _____
Age: _____ Email: _____ Hobbies: _____
Name of your Medical Doctor: _____ May we contact them: Y / N
Race: _____ Ethnicity: _____ Are you pregnant: Y / N
How did you hear about our clinic: _____ Preferred Language: _____
Emergency Contact Name & Phone #: _____ Relation: _____

What is your chief complaint: _____
_____
Date of your injury: _____ Work related: Y /N Auto Accident related: Y /N
Have you received Chiropractic Care before: Y / N Have you received Acupuncture before: Y / N

Do you smoke Cigarettes: Y / N Currently: Y / N Formerly: Y / N Never
Do you drink Alcohol: Y / N If yes, how often: _____ How much: _____
Do you use Recreational Drugs: Y / N What type: _____

Do you have a Family History of: (circle all that apply)
Heart Disease Arthritis Hypothyroid Diabetes (Type I / Type II) Seizures
Stroke Osteoporosis Rare Genetic Disease (type): _____
Cancer (type): _____

Do you have a Past Medical History of: (circle all that apply)
Lower Back Pain Stroke Thyroid Disease Diabetes (Type I / Type II)
Sciatic Pain Birth Control Pills Auto Accidents Hormone Replacement
Hypertension Head Trauma Heart Attack Osteoporosis
Blood Clots Neck / Back Trauma Balance Problems Dizziness
Cancer (type): _____ Numbness on 1/2 of your Face or Body

Will you be filing through insurance? If yes, please provide insurance company name and member ID number. If not, please move on to the next page.

Provider: _____ Member ID: _____

Please list any Allergies, Surgeries, Accidents, Falls, Pregnancies, or Hospitalizations:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list all Medications & Dietary Supplements that you are taking (list dosage & frequency):

_____
_____
_____
_____
_____
_____
_____
_____
_____

When discussing possible treatment options, do you prefer: **A lot of details** / **Just the bottom line**

Our team has four goals that drive our practice and quality of care. All are important to us, but out of these values, which would be your priority for today's visit?

Reduce Pain **Do Everyday Activities Normally**

Improve Overall Appearance **Maintain Optimal Health & Wellness**

Are you willing to do your part to help us achieve your goal? **Yes / No**

Looking at this list, would any of these be a possible barrier to you when considering treatment?

Fear **Time** **Budget** **Trust**

IF YOU HAVE ANY QUESTIONS OR CONCERNS WITH THE INFORMATION BELOW, IT IS YOUR RESPONSIBILITY TO ADDRESS THOSE CONCERNS WITH THE DOCTOR.

Informed Consent, Financial Responsibility, and Assignment of Benefits:

As with al medical or chiropractic treatments, I acknowledge and understand that there are inherent risks to receiving care including but not limited to sprains, strains, ,fractures, dislocations, muscle pain, bruising, and stroke. Statistically, these risks are extremely rare and uncommon (1 in 1-5 million in the case of strokes), especially when compared to those risks related with alternative treatment options for my condition including the use of over the counter analgesics, prescriptions drugs, and surgery. Due to that fact, I will not hold the physician or staff responsible for those risks listed above. In addition, I understand that the risk and danger of allowing my condition to go untreated may lead to further deterioration of my condition with possible serious and/or permanent consequences to my health. I acknowledge and understand that the use of certain prescription medications (i.e. birth control pills, hormone replacement, aspirin, Coumadin), illicit drug or alcohol use, and cigarette smoking may increase these risks and further inhibit proper healing. I also understand that if I am accepted as a patient, and if I receive care, that I am the ultimate responsible party on my account regardless of the actions of any 3rd party carrier (insurance company). I agree that should my account become delinquent, i will be responsible for all collection costs, including but not limited to the outstanding balance, attorney fees, court costs, collection agency fees, and interest at the rate of 18% per annum (1.5% per month). By signing below, I also agree to allow the doctor to share any and all medical reports and findings with my primary care physician, and I allow the doctor to use my name and case history in monthly newsletters and/or patient testimonial booklets. Lastly, I understand that any physician at DeLand Chiropractic & Spinal Decompression cannot evaluate, examine, x-ray, diagnose, or treat me for my presenting condition without my signature below. by signing below, I acknowledge that I have weighed the risks versus benefits of treatment, and I give the doctor consent to treat me for my condition.

Print Name: _____ **Date**: _____

Signature: _____

Deland Chiropractic & Spinal Decompression
Jeremy Gordon, DC PA, Michael Munson, DC, Jason Job, DC, & John Damrath, DC
905 North Stone Street, Deland, FL 32720 (386) 734-9995

Patient Name: _____ **Identification Number:** _____

Advance Beneficiary Notice of Non-Coverage (ABN)

NOTE: If Medicare doesn't pay for the 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 forth below.

Items, Services, Procedures	Reasons Medicare May Not Pay	Estimated Cost
Examinations/Re-examinations	Not a Medicare Covered Service/Benefit	$50-$200
Mechanical Traction	Not a Medicare Covered Service/Benefit	$41
PEMF	Not a Medicare Covered Service/Benefit	$30-$100
Low Level Laser Therapy	Not a Medicare Covered Service/Benefit	$16
Maintenance Treatment	Not a Medicare Covered Service/Benefit	$27-$75
Electrical Stimulations	Not a Medicare Covered Service/Benefit	$39
DRX-9000	Not a Medicare Covered Service/Benefit	$165
Cold/Hot Packs	Not a Medicare Covered Service/Benefit	$21

WHAT YOU NEED TO KNOW:

- 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.

☐ **OPTION 1.** I want the items/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, you will refund any payments I made to you, less copays or deductibles.

☐ **OPTION 2.** I want the items/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.**

☐ **OPTION 3.** I don't want the items/services listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see Medicare would pay.**

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 received 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 Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Pain Disability Questionnaire

Patient Name: _____ Date: _____

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. **Does your pain interfere with your normal work inside and outside the home?**

Work Normally — Unable to work at all

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?

Take care of myself — Need help with all my personal care

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

3. Does your pain interfere with your traveling?

Travel anywhere I like — Only travel to see doctors

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

4. Does your pain affect your ability to sit or stand?

No problems — Can not sit/stand at all

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

5. Does your pain affect your ability to lift overhead, grasp objects or reach for things?

No problems — Can not do at all

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop or squat?

No problems — Can not do at all

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

7. Does your pain affect your ability to walk or run?

No problems — Can not walk/run at all

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

8. Has your income declined since your pain began?

No decline — Lost all income

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

9. Do you have to take pain medication every day to control your pain?

No medication needed — Medication needed throughout the day

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

10. Does your pain force you to see doctors much more often than before your pain began?

Never see doctors — See doctors weekly

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

11. Does your pain interfere with your ability to see people who are important to you?

No problem — Never see them

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

12. Does your pain interfere with recreational activities and hobbies?

No interference — Total interference

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

13. Do you need the help of your family and friends to complete everyday tasks?

Never need help — Need help all the time

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?

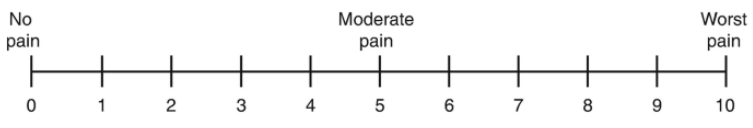
No depression/tension — Severe depression/tension

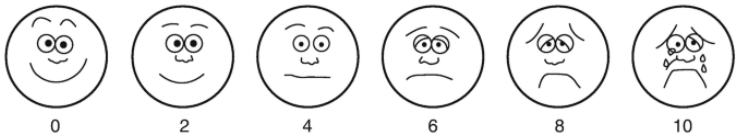
0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

15. Are there emotional problems caused by your pain that interfere with your family, social and/or work activities?

No problems — Sever problems

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10





DeLand Chiropractic & Spinal Decompression

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____ ZIP: _____

AUTHORIZATION

I authorize **DELAND CHIROPRACTIC & SPINAL DECOMPRESSION** to request and/or release the disclosure for the protected health information described below to and/or from the following individual/organizations:

Name of Practice/Organization: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

EFFECTIVE PERIOD

This authorization for release of information covers the period of healthcare from this date forward unless I revoke the authorization in writing. I understand that this for will be placed in my patient chart and maintained for six years.

ACKNOWLEDGEMENT

I acknowledge that Deland Chiropractic & Spinal Decompression has issued or offered to issue me a copy of the Notice of Privacy Practices. This notice describes how medical information about me may be used and disclosed and how I may obtain access to this information.

_____ _____

Signature of Patient/Guardian Date

_____

Print Name of Patient/Guardian

DeLand Chiropractic & Spinal Decompression

Dr. Jeremy M. Gordon
Dr. Michael T. Munson
Dr. Jason T. Job
Dr. John J. Damrath

905 North Stone Street – DeLand, FL 32720 | Phone (386)734-9995 Fax (386)734-9949

Nutritional Counseling - DRX Spinal Decompression - Chiropractic - Wellness - Acupuncture - Ideal Protein Weight Loss

Assignment, Lien and Authorization of Benefits

I, _____, hereby authorize and direct you, my insurance company, and/or attorney, to pay directly to DeLand Chiropractic and Spinal Decompression such sums as may be due and owing this office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, to withhold such sums from any disability benefits, medical payments benefits, "no-fault benefits", health and accidental benefits, workmen's compensation benefits, or any other insurance benefits obligated to reimburse me or from my settlement, judgment or verdict on my behalf as may be necessary to adequately project this office. I hereby further give a lien to said office against any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by this office. Signature of this document authorizes the release of any medical or other information necessary to process this claim, and I request payment of government benefits and authorize payment of medical benefits to the undersigned physician or durable medical goods supplier for goods or services provided. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

In the event my insurance company which is obligated to make payments to me for the charges incurred at this office refuses to make such payments, upon demand of this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to prosecute said cause of action either in my name or in the office's name and further I authorize this office to compensate settle or otherwise resolve said claim or cause of action as they see fit.

DeLand Chiropractic and Spinal Decompression accepts the aforesaid assignment and hereby notifies any insurer issuing payment that DeLand Chiropractic and Spinal Decompression objects to any repricing or reduction of billed amounts unilaterally made by any insurer. Any such reduced payments issued by any insurer are accepted under protest and without waiving any right of the provider to pursue all legal remedies against the insurer.

I, _____, understand that I remain personally responsible for the total amounts due the office for their services that are not paid by the insurance company.

I, _____, authorize the office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this assignment, lien and authorization. I agree that the above-mentioned office be given power of attorney to endorse/sign my name on any and all checks for payment of my doctor (medical) bill.

Please read this document completely before signing. If you do not understand this document or have any questions about this document, please ask us to explain it to you. If there is any portion of this document that you so mot wish to authorize, we will remove that portion from this document. Your signature below is your agreement you fully understand this document and you fully agree to the terms of this document.

_____ _____

Signature of Patient/Guardian Date

_____ _____

Print Name of Patient/Guardian Date