JointFit, PA Chiropractic & Sports Medicine Center **Confidential Patient Information**

3252 Kimball Ave Manhattan, KS Phone (785) 320-6868 Fax (785) 320-6861 Website: www.jointfitchiropractic.com

Office Use Only:
Patient ID Number: ____________
Dr. Richard E Foveaux DC, MS, CSCS
DX: ________, ________, ________,
________, ________

Date: ___/___/_____

Patient's Full Name ______________________________

Home Phone: ____________ Cell Phone: ____________ E-Mail: ____________

☐ Male ☐ Female Age: ________ Date of Birth: ___/___/_____ Social Security # _____-_____-_____

Mailing Address: ____________ City: ____________ State: ______ Zip: ________

☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced Number of Children/Ages ____________

Occupation: ____________ Hours/Week ______ Employer: ____________ Business Phone ____________

Spouse's Name: ____________ Employer: ____________ Business Phone ____________

Emergency Contact: ____________ Relationship: ____________ Phone: ____________

Address: ____________ City: ____________ State: ____________ Zip: ____________

Family Physician: ____________ City: ____________ State: ____________ Phone ____________

Payment Method: ☐ Cash ☐ Check ☐ MasterCard/Visa ☐ Insurance Do You Have Health Insurance? ________

Primary Insurance Company ____________ Insured's Name ____________

ID# ____________ Group# ____________ Parents/Spouse DOB (if applicable): ___/___/_____

Secondary Insurance Company ____________ Insured's Name ____________

ID# ____________ Group# ____________

Previous Chiropractic Care: ☐ Yes ☐ No If Yes, for what Problem: ____________

Doctor's Name ____________ City: ____________ State: ____________

Referred By (Friend, Relative, or Physician) : ____________

Is Today's Visit Due To A Work Related Injury: ☐ Yes ☐ No
Is Today's Visit Due To A Personal Injury or Auto Accident: ☐ Yes ☐ No
(If yes to either questions above, please check with receptionist, additional information is needed)

Date Of Injury: ____________

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical or emotional condition and/or health history to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you , I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. However, it is understood that all reasonable efforts have been made to collect the sums due from the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what was due, I personally owe you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state of Kansas.
5. I further agree that this Authorization and Assignment is irrevocable until all moneys owed JointFit, PA are paid in full.

Patient Signature ______________________ Date ___/___/_____

JointFit, PA Chiropractic & Sports Medicine Center | **Confidential Patient History**

3252 Kimball Ave Manhattan, KS 66503 Phone: 785-320-6868 jointfitchiropractic@live.com www.jointfitchiropractic.com

Dear Patient: Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Chief complaint____

Secondary or related complaint(s) if any:______________________________

Date of Onset: ____________ Was the Onset ☐ Gradual ☐ Sudden Since onset, has it gotten: ☐ Worse ☐ Better

Describe what caused the pain:__________________________________

PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP EXPLAIN YOUR **CHIEF COMPLAINT**:

Describe the quality of the complaint/pain:
- ☐ sharp
- ☐ dull/ache
- ☐ throbbing
- ☐ tingling/numbness
- ☐ other:________________

Describe if pain is in a single spot or does is spread out:
- ☐ radiating dull, deep ache
- ☐ pin point
- ☐ burning, sharp stabbing, tingling, numb
- ☐ other:________________

How often are you aware of the pain:
- ☐ intermittent (less than 25% of time when awake)
- ☐ occasional (25-50% of time when awake)
- ☐ frequent (50-75% of time when awake)
- ☐ constant (75-100% of time when awake)

Does any of the following make the pain worse:
- ☐ lifting/bending/pushing/pulling
- ☐ cough/sneeze/bowel movement
- ☐ driving/riding/sitting
- ☐ walking/running/standing
- ☐ other:________________

Does any of the following make it better:
- ☐ rest/laying down
- ☐ sitting
- ☐ walking/exercise
- ☐ other:________________

Does it interfere with your daily activities:
- ☐ minimal (annoyance, no impairment)
- ☐ slight (tolerated, some impairment)
- ☐ moderate (marked impairment)
- ☐ marked (preclude any activity)

Have you detected any possible relationship of your current complaint with any of the following:

☐ Muscle Weakness ☐ Bowel/Bladder problems ☐ Digestion ☐ Cardiac/Respiratory ☐ Other:____________

Have you tried any self-treatment or taken any medication (over the counter or prescription): ☐ Yes ☐ No

If yes, explain;____________________________ Results:____________

What medications are you currently taking?____________________________

Are you currently pregnant? ☐ Yes ☐ No Are you currently taking anti-coagulant or blood thinning medication? ☐ Yes ☐ No

What type of care are you interested in: ☐ Pain relief only ☐ Healing of current condition ☐ Optimizing your health ☐ All three

What is your long-term goal from treatment (e.g. play a round of golf without pain)?____________________

OFFICE NOTES :____

JointFit, PA Chiropractic & Sports Medicine Center **Confidential Patient History**

3252 Kimball Ave Manhattan, KS 66503 Phone: 785-320-6868 jointfitchiropractic@live.com www.jointfitchiropractic.com

In general, would you say your health is (check one): ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

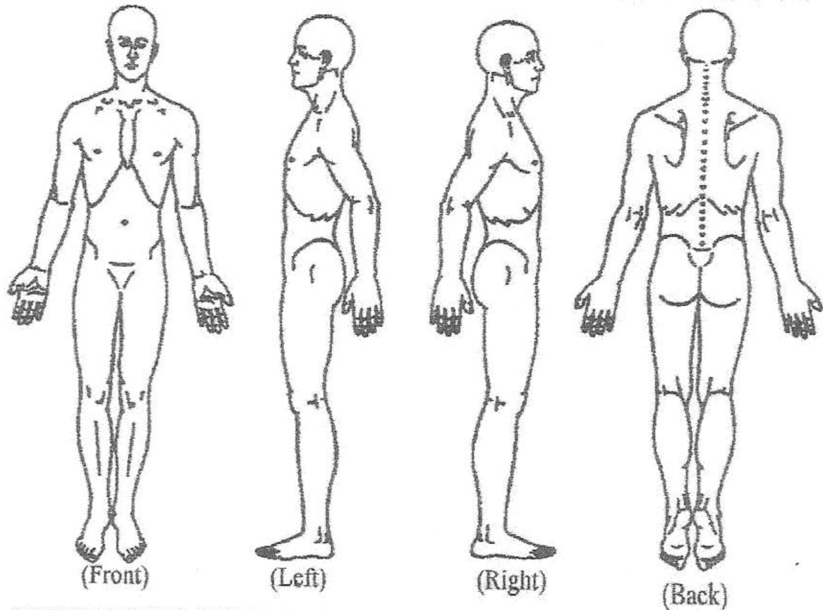
PAST HEALTH HISTORY:

1. Have you ever experienced your present problem before for which you are consulting us: ☐ Yes ☐ No If yes, When:____________
   Was treatment provided: ☐ Yes ☐ No If yes, By whom:________________________ Outcome:____________
2. Have you **ever** had a **stroke** or issues with **blood clotting**? ☐ Yes ☐ No If yes, when: ____________________
3. Have you recently experienced **dizziness**, unexplained **fatigue**, **weight loss**, or **blood loss**? ☐ Yes ☐ No If yes, explain:____________
4. Have you **ever** had any **major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries?** ☐ Yes ☐ No

Date	Injury/Fracture/Illness/Surgeries	Treatment	Results

PAIN CHART
Please Mark Areas of Pain using these Codes!

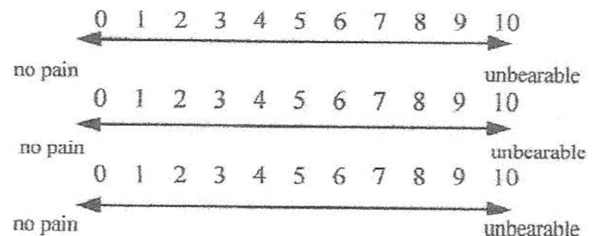
+++	Burning
###	Dull/Ache
***	Numbness/Tingling
═══	Throbbing
000	Stabbing/Sharp



SEVERITY OF PAIN

List region of pain and circle the number which represents the intensity of your pain.

1. Complaint:____________________
2. Complaint:____________________
3. Complaint:____________________



INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists whom perform manipulation are required by law to obtain your informed consent before starting treatment.

I____, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware the there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as get- ting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

Functional Dry Needling: Involves inserting a tiny monofilament needle in a muscle or muscles in order to release shortened bands of muscle to decrease trigger point activity. This technique is used to resolve pain and muscle tension, and promote healing. The most serious risk with FDN is accidental puncture of lung, although this is very rare. If this were to occur, it may likely require a chest x-ray and no further treatment. With my signature below, I here-by consent to the performance of this procedure. You have the right to refuse this procedure at any time during treatment.
Please answer the following questions before receiving the dry-needling procedure.

*******Are you pregnant? Yes or No*******
*******Are you immune-compromised? Yes or No *******
*******Are you taking blood thinners? Yes or No*******

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

____ Signature of Patient Date_______________________

____Signature of Parent or Guardian (if a minor) Date_______________________

JointFit, PA Chiropractic & Sports Medicine Center
Financial/Privacy Policy and Disclaimer

Insurance Verification

• **Insurance verification is not a guarantee of payment.** Verification is only a quote of patient benefits. Insurance companies review charges individually and make payment accordingly. **Charges not covered by insurance are the patient's responsibility and due within 30 days of billing.**

Deductible Payments

• **It is our policy to collect at time of service.** Once we receive an "Explanation of Benefits" report from the patient's insurance company, we will bill or credit the account for the remaining balance. Reimbursement checks can be issued upon request.

Collection of Patient Balance

• Co-payments and Co-insurance is the patient's responsibility and will be collected at the time of service.

• If the "Explanation of Benefits" report shows the patient has an outstanding balance from services not covered by the individual insurance company, patients will receive a bill outlining these outstanding charges. **Upon receipt, payment is due within 30 days. After 45 days, it is the clinic's policy to turn unpaid accounts over to a collections agency unless prior arrangements have been made.**

Returned Checks

• It is our policy to collect $35.00 for checks that are returned to us. This is to cover any fees that apply from the transaction

Appointments

• If unable to keep an appointment, as a courtesy to our staff and other patients please give 24-hour notice. If it is a continual problem there will be a **$35 charge during business hours and $50 charge outside of business hours** added towards your account each visit that is missed. The patient will be responsible for payment.

Financial Policy Questions

• We are happy to address questions regarding your account at any time. Please direct accounting questions to our billing administrator(s), Lexi Harp or Jennifer Foveaux.

HIPPA Privacy Policy

• Attached to the patient information packet at the back of these forms is the HIPPA Notice of Privacy Practices Policy for you.

• By signing below, the patient acknowledges that he/she has received the HIPPA Privacy Policy and that he/she understands and will comply with our financial policies.

Contact Release Information

• I agree to permit JointFit Chiropractic & Sports Medicine Center and their business associates to contact me, and all other responsible parties on my account, on our cell phone or other mobile devices concerning any and all aspects of my account.

______________________________ ______________

Patient Signature **Date**

SCHEDULE OF FEES
AS OF 5/1/2016

Code	Description	Amount	Type of Charge
29280	Taping/ Bracing Hand	$10.00	Service
29540	Taping/Bracing Foot/Ankle/Leg	$10.00	Service
97012	Mechanical Traction for Neck or Back	$20.00	Service
97014	Electrical Stimulation of Muscle. Soft Tissue	$20.00	Service
97035	Therapeutic Ultrasound	$20.00	Service
97110	Therapeutic Exercise (Acute P.T. care)	$35.00	Service
97112	Neuro-muscular Re-education Training	$35.00	Service
97116	Gait Training	$35.00	Service
97140	Manual Therapies (Trigger point work, mobilization, myofascial release)	$35.00	Service
97530	Therapeutic Activities (Advanced dynamic P.T. to improve function	$35.00	Service
97750	Physical Performance Test with Written Report	$35.00	Service
98940	Spinal Manipulation (Adjustment) 1-2 Regions	$40.00	Service
98941	Spinal Manipulation (Adjustment) 3-4 Regions	$54.00	Service
98942	Spinal Manipulation (Adjustment) 5 Regions	$60.00	Service
98943	Extremity Manipulation (adjustment)	$38.00	Service
99201	New Patient Focused Exam	$45.00	Service
99202	New Patient Expanded Problem Focused Exam	$70.00	Service
99203	New Patient Detailed Exam	$95.00	Service
99204	New Patient Comprehensive Exam/ Moderate Complexity	$135.00	Service
99205	New Patient Comprehensive Exam/ High Complexity	$150.00	Service
99211	Existing Patient Minimal Exam	$25.00	Service
99212	Existing Patient Problem Focused Exam	$40.00	Service
99213	Existing Patient Expanded Exam	$55.00	Service
99214	Existing Patient Detailed Exam	$75.00	Service
99215	Existing Patient Comprehensive Exam	$115.00	Service
96116	Neurobehavioral Status Exam "Concussion Testing"	–	Service
99385	DOT Exam (Initial Comprehensive Medical Exam-Adult)	$85.00	Service/Patient
76881	Diagnostic Ultrasound Joint/Extremity/Soft Issue (Full Exam)	$230.00	Service
76882	Diagnostic Ultrasound Joint/Extremity/Soft Issue (Limited)	$55.00	Service
	Half Foam Roll	$20.00	Patient
	Full Foam Roll	$20.00	Patient
	Cervical Denneroll	$50.00	Patient
	Aline Insole and Fitting	$100.00	Patient
	Biofreeze	$12.00	Patient

I acknowledge that I have read and understand the fee schedule of JointFit, Pa., that fees are based upon services performed, and that total visit fees may vary. I am responsible for payment for services that I receive or those that insurance may not fully cover. I understand that payment arrangements may be possible and I should inform JointFit of financial difficulty prior to receiving services.

Print Name: ______________________ Signature: ______________________ Date: ____________