Your Family Chiropractic LLC. Patient Questionnaire
Dr. Kayla J. Madler

Please provide a copy of your insurance card & a picture I.D. to the front desk

Patient Information (Please Print)

Name_____ Date _____ Birth Date _______________

Mailing Address_____ City_____ State_____Zip_____

SS#_____ Ethnicity (please check one) ☐Hispanic **or** ☐Non-Hispanic Sex _____

Race_____ Preferred Language _____ Height _____ Weight _____

Home #(_____)_____ Cell #(_____)_____ Work #(_____) _____

E-mail Address_____

Employer _____ Occupation _____ #years _____

Emergency Contact_____ Phone #_____ Relation_____

Whom may we thank for referring you to us? _____ **OR**

How did you find us: Internet?_____ Yellow Page Ad?_____ Other? _____

Name of local primary Physician: _____ May we contact them?_____

Symptoms

Main Complaint_____ How Bad? _____ How Often?_____

When did it start? _____Getting Worse? _____ Getting Better? _____

What activity bothers it the most? _____

When is it at its best?_____ When is it at its worst?_____

Rate the pain - (0 is pain free - 10 is unbearable pain) 1 2 3 4 5 6 7 8 9 10

Other Chiropractors?_____ Positive Experience?_____

Other type of physician or therapist?_____ Positive Experience? _____

Secondary Complaint_____

Health History

Tobacco or Alcohol Use-(please check)

Tobacco Use? ☐Yes ☐No ☐Quit

If yes, type, quantity per day, & how long? _____

Alcohol Use? ☐Yes ☐No

If yes, how many drinks per week?_____

Female Only –

How many children?_____ Pregnant?_____ Taking Birth Control Pills?_____

Nursing? _____ Date of last Menstrual Cycle_____ Date of last Mammogram _____

Please check all that apply to you:

☐Actinic Keratosis	☐COPD	☐Migraines	☐Fractures
☐Asthma or Hay Fever	☐Arthritis	☐Parkinson's	☐Osteoporosis
☐Pacemaker	☐Gout	☐M.S.	☐Herniated Disc
☐Chemical Dependency	☐Chronic Fatigue	☐ Epilepsy	☐Fibromyalgia
☐Melanoma	☐Heart Disease	☐Stroke	☐Rheumatoid
☐Kidney Stones	☐Kidney Disease	☐Hepatitis	☐High Blood Pressure
☐Tuberculosis	☐Diabetes	☐Liver Disease	☐Back Problems
☐Allergies	☐Prostate Problems	☐Emphysema	☐High Cholesterol

☐ Cancer (Type) _____-

Numbness on inner thighs? YES NO
Any unexplained weight loss? YES NO
Do you take immunosuppressants? YES NO

Bladder or bowel problems? YES NO
Pain not improved with rest? YES NO
Number of Corticosteroid shots that you have Received? _____

Other Information –

If you are 65+ years old: Have you received the Pneumonia Vaccination? ☐Yes or ☐No
Previous Surgeries and Dates: _____
_____

List ALL Medications you are currently taking: **Please Print** *(If you have a list please give it to the front desk)*

Allergies (Prescription Drugs and Environmental)	Current Medication (Exclude Supplements)

What supplements do you take? _____
_____

What kind of exercise do you do and how much? _____

*All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and I will be responsible for any outstanding amount owed this office. All outstanding balances are subject to interest and/or late fees.

Patient Signature_____ Date_____

Chiropractic Informed Consent

To the Patient: Please read this entire document prior to signing. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The primary treatment I use as a doctor of chiropractic is spinal manipulative therapy. I may use my hands or a mechanical instrument upon your body in such ways as to move your joints. This may cause an audible "pop" or "click", similar as you may experience when you "crack" your knuckles. You may feel a sense of movement.

As part of the analysis, examination, and treatment, you are consenting to the following procedures as needed:

Spinal manipulative therapy, vital signs, range of motion testing, postural analysis, muscle strength, hot/cold pack therapy, palpation, orthopedic testing, neurological testing, traction, electrical muscle stimulation, ultrasound, urinalysis, blood testing, hair analysis, and x-ray.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contra-indications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me. The incidences of these complications are very rare.

Other treatment options for your condition may include: Self-administered over the counter analgesics and rest, medical care, hospitalization, surgery, and possibly others. If you choose one of these options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician. Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

Notice of privacy practice summary

This summary discloses how health information about you may be used.

Your Family Chiropractic LLC. uses health information about you for treatment, to obtain payment for treatment with your authorization as required, for administrative purposes, and to evaluate the quality of care you received.

Your Family Chiropractic LLC. will not disclose your information to others unless you tell us to do so or unless the law authorizes us to do so.

Your Family Chiropractic LLC. may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Your Family Chiropractic LLC. may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations. You have a right to request restriction, request a report and retain a copy of your health record, request communication of your information by alternative means at alternative location, revoke your authorization and request an accounting of your health records.

You may complain to the Privacy Officer and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Your Family Chiropractic LLC. must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or complaints, please contact at 307-547-3330.

I have read and understand the above:

Signature _____ Date _____

If under 18 years of age, parent or guardian's signature _____

Medicare Informed Consent

Relative Contraindications:

Do you have any of the following conditions? (Please check all that apply)

❑Joint Hyper mobility ❑Osteoporosis/Osteopenia ❑Benign Bone Tumors ❑Bleeding Disorders ❑Blood Thinners ❑Progressive Radiculopathy

NOTE: *If you currently have, or have had, one of the above listed conditions, Medicare requires that we advise you that spinal manipulation and other forms of dynamic thrust* ***may be contraindicated*** *in your condition. By signing below, you consent to care and agree to inform this office if another health care provider tells you that you have one of these conditions.*

_____ _____

Patient Signature Date

Absolute Contraindications:

Do you have any of the following conditions? (Please check all that apply)

❑Rheumatoid Arthritis ❑Ankylosing Spondylitis ❑Ligament Laxity ❑Joint Dislocation ❑Recent/Unstable Joints ❑Unstable/Missing Dens at C2 ❑ Spinal Cancer ❑Spinal/Joint Infection ❑Myelopathy/Cauda Equina Syndrome ❑Vertebrobasilar Insufficiency Syndrome ❑Arterial Aneurysm

NOTE: *If you currently have, or have had, one of the above listed conditions, Medicare requires that we advise you that spinal manipulation and other forms of dynamic thrust* ***is absolutely contraindicated*** *in the region of the spine that is affected. By signing below, you agree to inform this office if another health care provider tells you that you have one of these conditions.*

_____ _____

Patient Signature Date

****Have you received the Pneumonia Vaccination? ☐Yes or ☐No**

Notice Of Non-Coverage For Medicare Services

It is important that you understand that Medicare does **NOT** pay for **ALL** chiropractic services. Medicare only pays for chiropractic care that **THEY** consider medically reasonable and necessary.

Medicare will not pay for certain services in this office, including but not limited to:

1. Initial or Re-exams
2. X-rays;
3. Physical Therapy;
4. Nutritional Supplements;
5. Any tests performed in our office:
6. Maintenance care

Payment of services:

You will be required to pay the balance of your yearly deductible, co-payment and 100% of all non-covered services. Supplemental insurance may cover services that Medicare does not cover. If you are unable to pay any portion of your deductible or co-payments, please let us know immediately so that we can work out financial arrangements out with you.

_____

Print Patient Name

_____ _____

Patient Signature Date

Your Family Chiropractic LLC.

A. Notifier: YFC

B. Patient Name: _____ C. Identification Number: On File

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for ***items or services in box D***, 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 ***items or services in box D***.

D.	E. Reason Medicare May Not Pay:	F. Cost
98940-One to Two Level Adjustment **98941-Three to Four Level Adjustment** **98942-Five Level Adjustment**	**Medicare may deem these services as NOT medically necessary due to:** 1. Necessity may not be supported by the history or paperwork 2. Restoration of function is not occurring 3. Improvement of condition not possible	$31.00 $44.00 $54.00

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 items or services in box D.

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.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want to receive items or services in box D. 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.

☐ **OPTION 2.** I want to receive items or services in box D, 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 to receive items or services in box D. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

I. Signature:	J. Date:

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.