T 1 2 3

OMNI CHIROPRACTIC NEW PRACTICE MEMBER APPLICATION

Name______________________________________ **Date** ___/___/____ **Age**_______ **Male/Female**

Address______________________________________ **City**____________ **State**__________ **Zip** ____________

Phone: Cell________________ **Home**________________ **Cellular Provider** ____________________________

Email Address____**Date of Birth**_____/_____/_____________

Occupation________________________________ **Employer's Name**_________________________________

Single / Married / Divorced / Widowed **Spouse's Name**____________________________________

Number of Children____ **Names, Ages & Gender**____

____

Who may we thank for referring you? ____

LIST THE HEALTH CONCERNS THAT BROUGHT YOU INTO THIS OFFICE

Health Concerns: List according to severity	Rate of Severity 0= No pain 10= Unbearable	When did this start?	Has this happened before? When?	Was that an incident that this injury originated from?	Are Symptoms constant or intermittent?
1.					
2.					
3.					
4.					
5.					

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO

CHIROPRACTOR?_________________ **MEDICAL DOCTOR**_______________**? OTHER**____________

WHO AND WHEN?____

WHAT WERE THE RESULTS? FAVORABLE UNFAVORABLE (please explain) _____________________

____

CIRCLE ALL PROBLEMS YOU HAVE

DIZZINESS	THROAT ISSUES	KIDNEY PROBLEMS	LIVER DISEASE	NERVOUSNESS
HEADACHES	THYROID PROBLEMS	MID-BACK PAIN	SHOULDER PAIN	EPILEPSY
VERTIGO	ASTHMA	IRRITABLE BOWEL	CHORNIC FATIGUE	DISC PROBLEM
EAR INFECTIONS	ULCERS	SCIATICA	LUPUS	INFERTILITY
NAUSEA	NUMBNESS IN ARMS	NUMBNESS IN LEGS	FIBROMYALGIA	GASTIC REFLUX
TMJ	NUMBNESS IN HANDS	NUMBNESS IN FEET	CHEST PAIN	OTHER:
NECK PAIN	MENSTRUAL DISORDERS	LOW BACK PAIN	ARM PAIN	________
MIGRAINES	HEART DISORDERS	HIP PAIN	ADD/ADHD	________
ANXIETY	STOMACH DISORDER	LEG PAINS		________
CHRONIC SINUS	BLADDER PROBLEMS	KNEE PIAN	________	________

PLEASE MARK "P" FOR IN THE PAST, OR MARK "C" FOR CURRENTLY HAVE:

STROKE	***CANCER***	***HEART ATTACK***
SPINAL SURGERY	***SEIZURES***	***SPRIAL BONE FRACTURE***
SCOLIOSIS	***DIABETES***	***OSTEOARTHRITIS***
RHEUMATOID ARTHRITIS	***OTHER CONDITION DISEASE:***	________

LIST ALL SURGICAL OPERATIONS AND DATES OF OPERATION:________________

____

LIST ANY OTHER INJURIES TO YOUR SPINE, MINOR OR MAJOR, THAT THE DOCTOR SHOULD KNOW ABOUT:________________

LIST ALL OVER THE COUNTER & PRESCRIPTION MEDICATIONS YOU ARE ON:________________

____

WHEN WAS YOUR LAST AUTO ACCIDENT?________________

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES/NO

IF YOU HAVE, DR. & DATE________________

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? YES/NO **FRACTURED A BONE? YES/NO**

IF YES TO EITHER OF THE ABOVE, PLEASE DESCRIBE:________________

OTHER TRAUMA:________________

SOCIAL HISTORY

1. SMOKING: How often? □ Daily □ Weekends □ Occasionally □ Never
2. ALCOHOL: How often? □ Daily □ Weekends □ Occasionally □ Never
3. EXERCISE: How often? □ Daily □ Weekends □ Occasionally □ Never

. How does your present problem affect the following: HOBBIES – RECREATIONAL ACTIVITIES – EXERCISE:

____

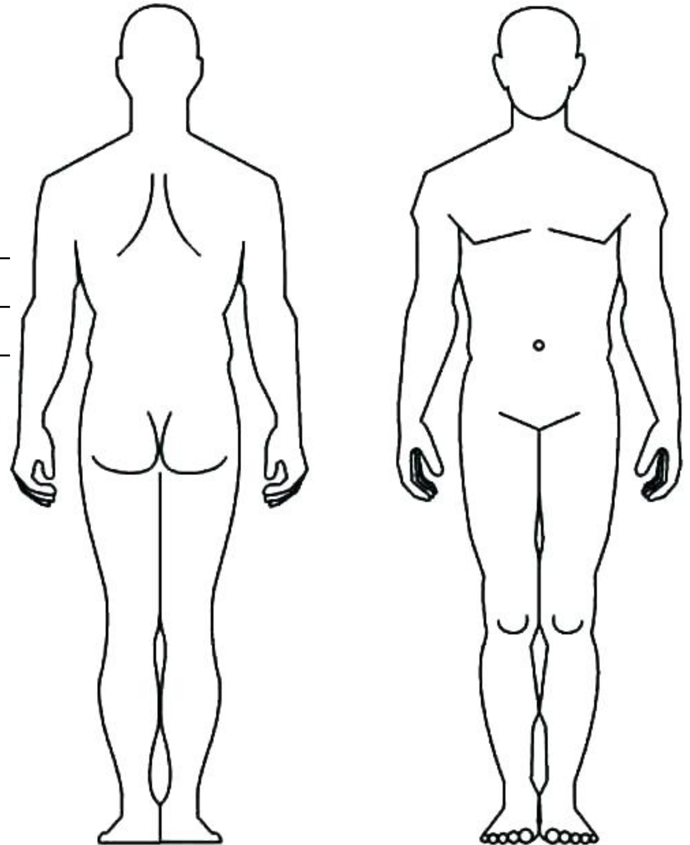
*

PLEASE MARK the areas on the diagram with the following

LETTERS to describe your symptoms:

R = Radiating B = Burning D = Dull A = Aching

N = Numbness S = Sharp/Stabbing T = Tingling



What relieves your symptoms? ________________________

____

____

What makes them feel worse?__________________ _

____

____

List Your Current Health Goals Below

HEALTH GOAL DATE TO ACCOMPLISH SIGNIFICANCE OF GOAL

Ex: Get rid of my headaches 1/1/2016 I want to play with my kids without pain, be able to spend more time with my family and have more energy.

1.____

____

2.____

____

3.____

____

ACTIVITIES OF DAILY LIVING

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY: EFFECT:

Carrying Groceries □ No Effect □ Painful (can do) □ Painful (limits)   Unable to Perform

Sit to Stand □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform

Climbing Stairs □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform

Pet Care □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform

Driving □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform

Extended Computer Use □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform

Household Chores □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform

Lifting Children □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform

Dressing □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform

Shaving □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform

Sexual Activities □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform

Sleep □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform

Static Sitting □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform

Static Standing □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform

Walking □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform

Washing/Bathing □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform

Sweeping/Vacuuming □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform

Dishes □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform

Laundry □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform

Yard work □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform

Garbage □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform

Concentration (Reading) □ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform

Other:_________________ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform

Other:_________________ No Effect □ Painful (can do) □ Painful (limits) □ Unable to Perform

Signature:____ Date___ / _____/______

QUADRUPLE VISUAL ANALOGUE SCALE (QVAS)

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

No pain= 0 Worst possible pain=10

1. How would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best? %

4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? %

Practice Member Name:____________________________ Date:_________________

Front desk will calculate the score.

Score: (Q1 +Q2 +Q4 = /3)x10= (Low Intensity = <50; High Intensity = >50)

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SCONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THE CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDING WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

PRINT PRACTICE MEMBERS NAME HERE____

PRACTICE MEMBER'S SIGNATURE OR GUARDIAN SIGNATURE

____DATE____________________

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW

WRITTEN CONSENT FOR A CHILD

NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD_________________________________

I AUTHORIZE DR. SIMEON SIAHMAKOUN AND ANY AND ALL OMNI CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD. AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY OMNI CHIROPRACTIC

GUARDIAN SIGNATURE____________________________________DATE_____________________

RELATIONSHIP TO MINOR/CHILD____

WITNESS SIGNATURE (OFFICE STAFF) ____________________________________DATE_________________

TERMS OF ACCEPTANCE

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-practice member relationship, it is our wish to provide each practice member with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.

B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve process.

C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by Doctors of Chiropractic in the United States alone.

D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of need.

E. Chiropractic does not seek to replace or compete with your medical, dental, or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.

F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.

G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

- By my signature below, I have read and fully understand the above statements. –

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

(Signature)____ (Date)_____________________

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

2. Obtain payment from third-party payers.

3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

(Signature)____ (Date)_____________________

X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES. AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES.

THE FEE FOR COPYING YOUR X-RAYS IS $15 PER VIEW AND WILL BE EMAILED. THIS FEE MUST BE PAID IN ADVANCED.

DIGITAL X-RAYS ON CD WLL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON ANY REGULAR PRACTICE HOURS DAY. PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. CHIROPRACTIC DOES NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.

BY SIGNING BELOW, YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

PRINT YOUR NAME HERE______________________________ **DATE**__________

SIGNATURE______________________________ **DATE OF BIRTH**____/____/____

FEMALE PRACTICE MEMBERS ONLY: TO THE BEST OF MY KNOWLEDGE,

I BELIEVE I AM NOT PREGNANT AT THE TIME THE X-RAYS ARE TAKEN AT OMNI CHIROPRACTIC.

SIGNATURE______________________________ **DATE**__________

DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE

Sex: □ M □ F

Lat Cervical______________________________

Flex/Ext______________________________

Lower Cervical______________________________

APOM______________________________

Other______________________________

Lateral Thoracic______________________________

AP Thoracic______________________________

Lateral Lumbar______________________________

AP Lumbar______________________________

Notes______________________________

____

____

Dr. or CA Initials__________

INSURANCE INFORMATION

NAME____SSN______________________________

CONTACT IN CASE OF EMERGENCY________________________________PHONE_____________

NAME OF PRIMARY INSURANCE CARRIER:____

Name of insured__________________________________Insured Date of Birth_____________________

Insured SSN____________________________________

NAME OF SECONDARY INSURANCE CARRIER:_______________________________________

Name of insured_________________________________ Insured Date of Birth_____________________

Insured SSN____________________________________

Insurance Policies and Fee Schedule

- **Consultation**- includes practice member history. This service is complimentary.
- **Assessment *(*new or establish practice member)**- includes one or more of the following: thermography, range of motion, orthopedic tests, motion and/or static palpation, leg check $65-$185.
- **Chiropractic Adjustment**- The actual re-alignment of the vertebra or other bones. $50-$80.
- **X-rays**- Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after a period of care. $50 per view.

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Simeon Siahmakoun, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. I understand that all professional services rendered are charged to the patient and that is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for the charges not covered by this assignment and that Omni Chiropractic reserves the right to add a $25.00 service charge to my account for any returned check or charge back. I authorize this facility along with any billing service and their collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology or by electronic mail, text messaging or by any other form of electronic communication.

Signed____Date________________

Explanation of Services

In the event that the Care Plan is not completed, Practice Member is responsible for the services already rendered and any credit or balance due will be determined once all explanation of benefits have been received. Services rendered are determined through each visit and service received over the course of time under care. This amount may differ from rate paid through monthly payments depending on how much care has been received or by thirty days after notice of discontinuation, whether verbal or written. It is the responsibility of the Practice Member to fill out any forms and document any changes needed regarding payments with the front office staff.
Standard rate for the adjustment is $50.

For use in insurance/personal injury/work comp claims:
____Insurance Disclaimer: A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the practice member's insurance at time of service
____Insurance Liability for Payment: Your health/auto insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized by your health/auto insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service.
____Beneficiary Agreement: I understand that my health/auto insurance company may deny payment for services received at Omni Chiropractic, for the reasons stated. If my health/auto insurance company denies payment (in whole or in part), I understand that I am personally and fully responsible for payment. I also understand that if my health/auto insurance company does make payment for services, I will be responsible for any co-payment, deductible, out of pocket, or coinsurance that applies.

____
Print Name

________________________________ ________________________________
Practice Member Signature Date

________________________________ ________________________________
Witness Signature Date