PATIENT APPLICATION for BARRETT SPINAL CARE, PC

Name: _____ (Age) _____ Gender: M F

Name you would like us to call you:_____

Home Address: _____ Home Phone: ( ) _____

City, State, Zip: _____ Work Phone: ( ) _____

Email Address: _____ Cell Phone: ( ) _____

Birth Date: _____ / _____ / _____ Social Security #: _____ - _____ -_____ Marital Status: S M D W

Names of Children: _____ Ages: _____

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

Emergency Contact:_____Relationship:_____ Phone Number:_____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? □ Yes □ No Who? _____ When? _____

Reason for visits: _____How did you respond? _____

Did your previous chiropractor take before and after x-rays? □ Yes □ No Did you know posture affects your health? □ Yes □ No

Are you aware of any of your poor posture habits? □ Yes □ No Explain: _____

Are you aware of any poor posture habits in your spouse or children? □ Yes □ No Explain: _____

HEALTH LIFESTYLE

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week other: _____

What activities? □ Running/ Jogging □ Weight Training □ Cycling □ Yoga □ Pilates □ Swimming _____

Do you smoke? Yes No How much? _____Do you drink alcohol? Yes No How much / week? _____

Do you drink coffee? Yes No How many cups / day? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

Medications: (please use the back of this sheet for additional space)

Medication (name, dosage, frequency, reason for taking) Medication (name, dosage, frequency, reason for taking)

_____ _____

_____ _____

_____ _____

Surgeries: (please use the back of this sheet for additional space)

Date / Type of Surgery Date / Type of Surgery

_____ _____

_____ _____

Females/ Pregnancies and outcomes: (please use the back of this sheet for additional space)

Pregnancies/Date of Delivery/Outcome Pregnancies/Date of Delivery/Outcome

_____ _____

_____ _____

Family Health History:

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases □ Adopted/Unknown □ Diabetes
□ Cardiac disease below age 40 □ Psychiatric disease □ Other _____ □ None of the above

Cause of parents or siblings death/ Age at death Cause of parents or siblings death/ Age at death

_____ _____

_____ _____

CERVICAL SPINE (NECK):

Do you experience…?

- ❑ Neck Pain
- ❑ Pain into your shoulders/arms/hands
- ❑ Numbness/tingling in arms/hands
- ❑ Hearing disturbances
- ❑ Weakness in grip
- ❑ Headaches
- ❑ Dizziness
- ❑ Visual disturbances
- ❑ Coldness in hands
- ❑ Low Energy/Fatigue
- ❑ TMJ/Pain/Clicking

THORACIC SPINE (MID BACK):

Do you experience…?

- ❑ Mid Back Pain
- ❑ Pain on Deep Inspiration/Expiration
- ❑ Pain into your Ribs/Chest
- ❑ Indigestion/Heartburn
- ❑ Shortness of Breath
- ❑ Reflux

LUMBAR SPINE (LOW BACK):

Do you experience…?

- ❑ Low back pain
- ❑ Weakness/injuries in your hips/knees/ankles
- ❑ Pain into your hips/legs/feet
- ❑ Numbness/tingling in your legs/feet
- ❑ Coldness in your legs/feet
- ❑ Muscle cramps in your legs/feet
- ❑ Constipation / Diarrhea
- ❑ Sexual dysfunction

REVIEW OF SYSTEMS

Have you had any of the following issues?

PULMONARY (LUNG-RELATED)
□ Asthma/difficulty breathing □ COPD
□Emphysema □ Other _____

NEUROLOGICAL (NERVE-RELATED)
□ Visual changes/loss of vision □ History of seizures
□ One-sided weakness of face or body □ Headaches
□ One-sided decreased feeling in the face or body
□ Memory loss □ Tremors □ Vertigo □ Strokes/TIAs
□ Loss of sense of smell □ Other _____

RENAL (KIDNEY-RELATED)
□ Renal calculi/stones □ Hematuria (blood in the urine)
□ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis
□ Other _____

HEMATOLOGICAL (BLOOD-RELATED)
□ Anemia □ Sickle-cell anemia □ Hemophilia
□ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/ Aleve, etc.)
□ HIV positive □ Enlarged lymph nodes □ Regular aspirin use
□ Abnormal bleeding/bruising □ Anticoagulant therapy
□ Hypercoagulation or deep venous thrombosis(history of blood clots)
□ Other _____

PSYCHOLOGICAL
□ Psychiatric diagnosis □ Depression □ Suicidal ideations
□ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other _____

CARDIOVASCULAR (HEART-RELATED)
□Heart surgeries □ Congestive heart failure
□ Murmurs or Valvular disease □ Heart attacks/MIs
□ Heart disease/problems □ Hypertension □ Pacemaker
□ Angina/chest pain □ Irregular heartbeat
□ Other _____

ENDOCRINE (GLANDULAR/HORMONAL)
□ Thyroid disease □ Hormone replacement therapy
□ Injectable steroid replacements □ Diabetes
□ Other _____

GASTROENTEROLOGICAL (STOMACH-RELATED)
□ Nausea □ Difficulty swallowing □ Ulcerative disease
□ Frequent abdominal pain □ Hiatal hernia
□ Constipation □ Pancreatic disease □ Irritable bowel
□ Hepatitis or liver disease □ Bloody/black tarry stools
□ Vomiting blood □ Bowel incontinence
□ Gastroesophageal reflux/heartburn □ Other _____

DERMATOLOGICAL (SKIN-RELATED)
□ Significant burns □ Significant rashes
□ Skin grafts □ Psoriatic disorders
□ Other _____

MUSCULOSKELETAL (BONE/MUSCLE-RELATED
□ Rheumatoid arthritis □ Gout □ Osteoarthritis
□ Broken bones □ Spinal fracture □ Spinal surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants
□ Joint surgery □ Other _____

Is there anything else in your past medical history that you feel is important to your care here? _____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient's Name:_____ If patient is a Minor, Parent's Name:_____

Signature:_____ **Date:**_____

NEW PATIENT HISTORY FORM

Symptom 1 (Main reason for visit; **Cirlce One**) Neck Mid-Back Low Back Other:_____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
  0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  Did the symptom begin suddenly or gradually? (circle one)
  How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing,
  other (please describe): _____
- What makes the symptom better? (circle all that apply):
  Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
  Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 (Second reason for visit; **Circle One**) Neck Mid-Back Low Back Other:_____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
  0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  Did the symptom begin suddenly or gradually? (circle one)
  How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing,
  other (please describe): _____
- What makes the symptom better? (circle all that apply):
  Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
  Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  Morning Afternoon Evening Night Unaffected by time of day

For additional symptoms, please see the office staff for another history form.

FINANCIAL POLICY

This agreement is between Barrett Spinal Care, P.C. as creditor, and the Patient/Debtor named on this form.

By executing this agreement, you are agreeing to pay for all services that are received.

Payment Options: ALL PAYMENTS ARE DUE ON THE DAY THAT THE SERVICES ARE RENDERED. If you have insurance, we require that your deductible and your percentage be paid at the time of service. **You may choose to pay cash, check or credit card.**

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Insurance I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is merely an estimate and not a guarantee of payment, it is the insurance company that makes the final determination of your eligibility. The Doctors office will provide required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company. It is also your responsibility to keep track of any annual insurance maximums. Claims are submitted promptly after treatment is rendered and if not paid by your insurance company by the 61st day after treatment, you will be billed and a finance charge will be charged on the balance remaining.

Finance Charges: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one and one-half percent (1.5%) per month or an **ANNUAL PERCENTAGE RATE** of eighteen (18%) percent. The finance charge on your account is computed by applying the periodic rate (1.5%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum finance charge is $.50. If the past due account is sent to collections, there will be an overall 30% added to the account for collection services (this is after the monthly finance charges have been added).

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Returned Checks: There is a fee (currently $35.00) for any checks returned by the bank and may be turned over to the District Attorney's office for restitution.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency you agree to pay all of the costs of the collection costs which incurred. The overall amount added to the account is 30% of the past due amount. If we have to refer collection of the balances to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Cherokee County, Oklahoma.

Doctor's Notes/Letters: Barrett Spinal Care will charge patients for letters or notes that are written for the following: absence of jury duty, insurance companies, attorney's office, narrative or report. These must be paid by the patient or guardian before it will be released and will not be billed to any insurance company.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee, if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, payment of bill remains the patient's responsibility after the insurance company has paid its portion. It is our office policy to file a Physician's Lien with the Cherokee County court house after a care plan has been completed or terminated. Additionally, we cannot bill your attorney or other party for charges incurred due to a personal injury after payment has been made from the primary insurance in the case.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect for all subsequent charges.

Patient's Name:_____ Date:_____

If patient is a Minor, Parent's Name:_____

Signature:_____

IF YOU HAVE PRIVATE OR GROUP INSURANCE, PLEASE READ AND SIGN THE RED SECTION (I). IF YOU HAVE MEDICARE OR A MEDICARE POLICY, PLEASE READ AND SIGN THE BLUE SECTION (II). PRIVACY CONSENTS ARE THE PURPLE SECTION (III). INITIAL ANY THAT YOU CONSENT TO. ONE ITEM MUST BE INITIALED, EVEN IF IT IS THE LAST ITEM. IF YOU ARE A PARENT/GUARDAIN, PLEASE READ AND SIGN THE GREEN SECTION (IV).

(I) ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on this document authorizes my provider to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature each and every claim to be submitted for myself and/or other dependants, and that I will be bound by the signature, though the undersigned had personally signed the particular claim.

I _____ hereby authorize _____
(Name of Insured) (Name of Insurance Company)

to pay and hereby assign directly to **Barrett Spinal Care, PC** all benefits, if any, otherwise payable to me for his/her service as described on the attached forms. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to **Barrett Spinal Care, PC**, will be credited to my account, in accordance with the above said assignment.

_____ _____
(Authorized Signature of Subscriber) (Date)

(II) MEDICARE AUTHORIZATION

IF YOU ARE COVERED BY MEDICARE, PLEASE SIGN AND DATE BELOW

I request payment of authorized Medicare benefits be made either to me or on my behalf to **Barrett Spinal Care, PC** for any services provided to me by that provider. I authorize any holder of medical information about me to the Center for Medicare and Medicaid Services (CMS) and it agents any information needed to determine these benefits payable to related services.

_____ _____
(Signature of Beneficiary) (Date)

(III) PRIVACY/MEDIA CONSENTS

Please initial by each group if you consent to the items listed. ATLEAST ONE ITEM MUST BE INITIALED!

_____ Here are a few examples of items you may receive in the mail:

- Appointment Reminder Cards / Reschedule Appointment Cards
- Complimentary Service Offers/ Special offers on discounts
- Greeting Cards / Birthday Cards

_____ I agree to allow a staff member of Barrett Spinal Care, PC to leave messages on my answering machine or voicemail regarding my appointments or other related information.

_____ I agree to allow a staff member of Barrett Spinal Care, PC send me electronic submissions regarding my appointments or other related information. (please check those that apply) _____texts _____ emails _____ other _____

_____ We will occasionally use your name or story in our office or on our media outlets (Facebook, www.barrettspinalcare.com, KEOK Radio, KTLQ Radio, Twitter, etc.) to help in the education of future patients.

- Patient Story Book / Patient Testimonies
- Internet Referral Board

_____ **I do not consent to any of the above listed Privacy/ Media Consents.**

(IV) CONSENT FOR MINOR

I know that I am responsible for, and agree to pay, all fees incurred at this office by my minor child. I understand that any insurance benefits that I may have, for my minor child, are a contracted arrangement between me and the insurance company. This office will be responsible for preparing notes, billing receipts, and informational reports as needed to aid in insurance payment/reimbursement. I realize that this office is not responsible to negotiate disputed benefits for me regarding my minor child. I understand that if my child is accepted as a patient at Barrett Spinal Care, PC, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved regarding chiropractic treatment will be explained to me upon my request. I am choosing for my child to be treated, for today and all future visits at this office, through the use of various types of chiropractic manipulations, diagnostic x-rays, and several types of physiologic modalities (physical therapy). I realize there is no guarantee of results and have been informed that some risks of treatment do exist. These risks could include, but are not limited to: sprains, dislocations, fractures, strokes, and disc injury. While I do expect my doctor to use his best judgment to choose the most appropriate care for my child's condition, I agree that the Doctor cannot foresee every possible complication or risk which could arise in my child's treatment.

Patient's Name:_____ If patient is a Minor, Parent's Name:_____

Signature:_____ **Date:**_____

Doctor's Name: **Ryan Barrett, DC** **Doctor's Signature:**_____

INFORMED CONSENT

To the patient: Please read this entire document prior to signing it. 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 nature of the chiropractic adjustment.

The primary treatment I use as Doctor of Chiropractic is a spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "click" or "pop", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

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

·Spinal Manipulative Therapy	·Palpation	·Vital Signs	·Range of Motion Testing
·Orthopedic Testing	·Ultrasound	·Postural Analysis	·Muscle Strength Testing
·Hot/Cold Therapy	·EMS	·Radiographic Studies	·Basic Neurological Testing

·Other (please explain):_____

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complication 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 may feel some stiffness and soreness during the first few days after treatment. I will make every reasonable effort during the examination to screen for contraindictations to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring

Fractures are rare occurrences and generally result from underlying weakness of the bone which I check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare, and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your treatment may include, but not limited to:

·Self administered, over-the counter analgesics and rest	·Hospitalization
·Medical care and prescription drugs such as anti-inflammatory, muscle relaxers and pain killers	·Surgery

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reverse mobility, which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment making more difficult and less effective the longer it is postponed.

For Women only

To the best of my knowledge I am _____ am NOT _____ pregnant and any staff member of Barrett Spinal Care, PC, has my permission to x-ray me for diagnostic interpretation. _____(please initial)

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have the above explanation of the chiropractic adjustment and related treatment. I have discussed/ will discuss it Dr. Ryan Barrett and have had/ will have my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved with undergoing treatment and decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consents to that treatment.

Patient's Name:_____ If patient is a Minor, Parent's Name:_____

Signature:_____ **Date:**_____

Doctor's Name: Ryan Barrett, DC **Doctor's Signature:**_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FOR BARRETT SPINAL CARE, PC

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

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the its *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Are there any other persons with whom we have permission to contact to discuss you (or your child's) medical condition? If so, please list them below.

Contact 1: _____
Name Relationship Phone Number

Contact 2: _____
Name Relationship Phone Number

Contact 3: _____
Name Relationship Phone Number

Patient's Name: _____ If patient is a Minor, Parent's Name:_____

Signature:_____ Date:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: