PATIENT APPLICATION for BARRETT SPINAL CARE, PC

Name: ____ (Age) _________ Gender: M F

Name you would like us to call you:____

Home Address: ____

City, State, Zip: ______________________________ Cell Phone: ( ) ____________ TEXT Y N

Email Address: __________________________________ Home Phone: ( ) ____________

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

Names of Children: ______________________________________ Ages: __________

Occupation: ____________________________________ Employer Name: ________________

Spouse's Name: ____________________________ Cell Phone: ( ) ____________________

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)

________________________ | ________________________

________________________ | ________________________

________________________ | ________________________

Allergies: (check all that apply)

☐ Animal ☐ Aspirin / Pain Medicine ☐ Bee/Wasp Stings ☐ Dairy Products ☐ Eggs ☐ Latex ☐ Mold

☐ Penicillin ☐ Ragweed/Pollen ☐ Seasonal Allergies ☐ Shellfish ☐ Soaps ☐ Wheat ☐ Other______________

Surgeries: (check all that apply)

☐ Appendix ☐ Back ☐ Brain/Tumor ☐ C-Section ☐ Carpal Tunnel ☐ Cervical Disc ☐ Chest ☐ Cleft Palate

☐ Disc (which area:______________) ☐ Elbow (L or R) ☐ ENT ☐ Foot (L or R) ☐ Gallbladder

☐ Gastrointestinal ☐ Hand (L or R) ☐ Heart (type):____________ ☐ Hernia ☐ Hip (L or R)

☐ Hip Replacement ☐ Jaw ☐ Knee (L or R) ☐ Knee Replacement (L or R) ☐ Leg (L or R) ☐ Lumbar Disc ☐ Neck

☐ Neurological ☐ Obstetrical ☐ Oral Surgery ☐ Podiatric ☐ Shoulder (L or R) ☐ Thoracic Disc ☐ Tonsils / Adenoids

☐ Wrist (L or R) ☐ Other____

Medical History: (check all that apply)

□ Ankle Pain (L or R)	□ Arm Pain (L or R)	□ Arthritis	□ Asthma
□ Back Pain	□ Broken Bones	□ Cancer:_______________	□ Chest Pain
□ Depression / Other Disorder	□ Diabetes	□ Dizziness	□ Elbow Pain (L or R)
□ Epilepsy	□ Eye/Vision Problems	□ Fainting	□ Fatigue
□ Foot Pain (L or R)	□ Genetic Spinal Disorder	□ Hand Pain	□ Headaches
□ Hearing Problems	□ Hepatitis	□ High Blood Pressure	□ Hip Pain (L or R)
□ Jaw/TMJ Pain (L or R)	□ Joint Stiffness	□ Knee Pain (L or R)	□ Leg Pain (L or R)
□ Low Back Pain	□ Menstrual Problems	□ Mid Back Pain	□ Minor Heart Trouble
□ Multiple Sclerosis	□ Neck Pain	□ Neurological Disorder	□ Pacemaker
□ Parkinson's Disease	□ Polio	□ Prostate Problems	□ Shoulder Pain (L or R)
□ Significant Weight Change	□ Spinal Cord Injury	□ Sprain / Strain	□ Stroke / Heart Attack
□ Stomach Problems	□ Tumor	□ Ulcers	□ Wrist Pain (L or R)
□ Anxiety	□ Heartburn	□ Vertigo	□ Constipation / Diarrhea
□ Other:_________________	□ Other:_________________	□ Sexual Dysfunction	□ Migraines

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

____

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

____

____

COMPLAINT 1

(For additional complaints, please see the office staff for another history form)

(Main reason for visit; **Cirlce One**) Neck Upper Back Mid-Back Low Back Other:__________________________

Condition started:____ □ Not sure when

Condition start details:____

Location: □ Left □ Right □ Both □ Centrally □ None

Pain Level: 1 2 3 4 5 6 7 8 9 10 □ None

Activities Affected Level: 1 2 3 4 5 6 7 8 9 10 □ None

Intensity: □ Minimum □ Mild □ Moderate □ Severe □ Unbearable □ None

Nature: □ Burning □ Dull Ache □ Numb □ Radiating pain □ Sharp □ Shooting □ Stabbing pain □ Tightness □ Tingling □ Throbbing Pain radiates to?____

Makes Pain Better: □ Acupuncture □ Chiropractic Therapy □ Heat □ Ice □ Massage Therapy □ Nothing Works □ Pain Medicine □ Physical Therapy □ Sleep/Rest □ Stretching □ Therapy □Other______________

Expectations: □ Become pain free □ Explanation of my Condition □ Learn how to care for this condition on my own □ Reduce Symptoms □ Resume Normal Activity

Frequency: □ Constantly (76-100 % of the day) □ Frequently (51-75% of the day) □ Occasionally (26-50% of the day) □ Intermittently: (0-25% of day) □ None

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:**_____________________________________

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 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
- Massage Therapy
- Manual Therapy
- Myofascial Release
- Trigger Point Therapy
- 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 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 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 contraindications 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 with 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 consent 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:**____

FINANCIAL POLICY

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

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies. By executing this agreement, you are agreeing to pay for all services that are received.

1. Our clinic has established a single fee schedule that applies to all patients for each service provided.
2. You may be entitled to a network contractual discount under the following circumstances:
   a. We are a participating provider in your health plan.
   b. You are covered by a State or Federal program with a mandated fee schedule.
   c. You are a member of ChiroHealthUSA, or any other Discount Medical Plan Organization we may join. Ask our staff for more information.

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.** 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.

Insurance: I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. Barrett Spinal Care, PC is 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 you understand that insurance carriers may deny any claim and that you are 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).

Past Due Accounts: If your account becomes past due, we will take the necessary steps to collect this debt. If we must refer your account to a collection agency, you agree to pay all of the costs of the collection costs which are incurred. The overall amount added to the account is 30% of the past due amount. In case of suit, you agree the venue shall be in Cherokee County, Oklahoma. You understand if this account is submitted to an attorney or collection agency, if we must 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. I authorize Barrett Spinal Care, PC to contact me via current and any future cellular phone number(s), email addresses, or wireless device(s) regarding my delinquent account(s) I owe to Barrett Spinal Care, PC. I authorize Barrett Spinal Care and its agents, representatives, and attorneys (including collection agencies) to use automated telephone dialing equipment, artificial or pre-recorded voice or text messages and personal calls or emails, in their effort to contact me for purposes of collecting and portion of my account which is past due.

Personal Injury / Accident: Currently, Barrett Spinal Care does not accept auto accident insurance as a form of payment. If you have been involved in an accident, payment will need to be made by you.

No-Show Policy: We make every effort to provide prompt medical care to all our patients. If you are unable to keep a scheduled appointment, please let us know **in advance**. A No-Show is when a patient fails to keep a scheduled appointment. A No-Show will generate a **$55** fee and three no shows may require that you seek your medical care elsewhere. If you are delayed and cannot make an appointment on time, please call to advise us of your situation and provide an estimated time of arrival. Any significant delay may require the visit to be rescheduled. The No-Show fee will be charged directly to the patient/guardian, NOT the patient's insurance company or Medicare. All No-show fees must be paid prior to the next appointment in order to be seen and cannot be paid with any Health Benefit Savings cards or Discount Medical Plans. If not paid, this balance can be turned over to our collection agency. Reminder text messages are a courtesy, but it does not excuse a missed appointment if one fails to be sent.

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 call and/or 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 for negotiating 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:**____

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 by Barrett Spinal Care, PC 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.

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information (PHI) may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you, and created or received by this office.
*You will be given a copy of Patient Privacy Policy for your records, or it is available on our website at barrettspinalcare.com.

I have received a copy of the Notice of Patient Privacy Policy. ___________ Patient Initials

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.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Notice of Treatment in Open or Common Areas
Describe and notify private areas in our office available upon request.

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

Contact 1: ____
Name Relationship Phone Number

Contact 2: ____
Name Relationship Phone Number

By my signature below I give my permission to use and disclose my health information.

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:

ITEM 070-5962/25950 © May 2002

Patient Name:____Date:___________________

COMPLAINT 2

(Main reason for visit; **Cirlce One**) Neck Upper Back Mid-Back Low Back Other:____________________________

Condition started:____ ◻ Not sure when

Condition start details:____

Location: ◻ Left ◻ Right ◻ Both ◻ Centrally ◻ None

Pain Level: 1 2 3 4 5 6 7 8 9 10 ◻ None

Activities Affected Level: 1 2 3 4 5 6 7 8 9 10 ◻ None

Intensity: ◻ Minimum ◻ Mild ◻ Moderate ◻ Severe ◻ Unbearable ◻ None

Nature: ◻ Burning ◻ Dull Ache ◻ Numb ◻ Radiating pain ◻ Sharp ◻ Shooting ◻ Stabbing pain ◻ Tightness
◻ Tingling ◻ Throbbing Pain radiates to?____

Makes Pain Better: ◻ Acupuncture ◻ Chiropractic Therapy ◻ Heat ◻ Ice ◻ Massage Therapy ◻ Nothing Works
◻ Pain Medicine ◻ Physical Therapy ◻ Sleep/Rest ◻ Stretching ◻ Therapy ◻Other_____________

Expectations: ◻ Become pain free ◻ Explanation of my Condition ◻ Learn how to care for this condition on my own
◻ Reduce Symptoms ◻ Resume Normal Activity

Frequency: ◻ Constantly (76-100 % of the day) ◻ Frequently (51-75% of the day) ◻ Occasionally (26-50% of the day)
◻ Intermittently: (0-25% of day) ◻ None

COMPLAINT 3

(Main reason for visit; **Cirlce One**) Neck Upper Back Mid-Back Low Back Other:____________________________

Condition started:____ ◻ Not sure when

Condition start details:____

Location: ◻ Left ◻ Right ◻ Both ◻ Centrally ◻ None

Pain Level: 1 2 3 4 5 6 7 8 9 10 ◻ None

Activities Affected Level: 1 2 3 4 5 6 7 8 9 10 ◻ None

Intensity: ◻ Minimum ◻ Mild ◻ Moderate ◻ Severe ◻ Unbearable ◻ None

Nature: ◻ Burning ◻ Dull Ache ◻ Numb ◻ Radiating pain ◻ Sharp ◻ Shooting ◻ Stabbing pain ◻ Tightness
◻ Tingling ◻ Throbbing Pain radiates to?____

Makes Pain Better: ◻ Acupuncture ◻ Chiropractic Therapy ◻ Heat ◻ Ice ◻ Massage Therapy ◻ Nothing Works
◻ Pain Medicine ◻ Physical Therapy ◻ Sleep/Rest ◻ Stretching ◻ Therapy ◻Other_____________

Expectations: ◻ Become pain free ◻ Explanation of my Condition ◻ Learn how to care for this condition on my own
◻ Reduce Symptoms ◻ Resume Normal Activity

Frequency: ◻ Constantly (76-100 % of the day) ◻ Frequently (51-75% of the day) ◻ Occasionally (26-50% of the day)
◻ Intermittently: (0-25% of day) ◻ None