INFORMED CONSENT FOR CHIROPRACTIC CARE

By beginning chiropractic care at Compass Chiropractic LLC, I acknowledge that the objective of the chiropractor is to identify and correct vertebral subluxations through a chiropractic adjustment. This is a specific manual force applied to the spine by hand or instrument, in which a controlled thrust or impulse is delivered to the involved area. The doctor may need to touch sensitive areas of the body to properly deliver an adjustment or analyze my spine. I acknowledge that techniques may require the body to be placed into awkward positions to better receive treatment. I request and consent to receiving chiropractic care, diagnostic X-rays, and other related therapies, on myself (or on the patient for whom I am legally responsible) by any licensed doctor of chiropractic employed at Compass Chiropractic LLC.

Many patients report benefits while under chiropractic care including increased range of motion and pain relief. Although most people respond positively to care, no guarantees of cure have been implied or given. As with any health care procedure, there are some associated risks which your doctor is required to bring to your attention. Though uncommon, you should note the possibility of fracture, disc injury, muscle strain, ligament sprain, dislocation, and costovertebral separation. Strokes have been reported following chiropractic manipulation. The probability of this is exceedingly rare, estimated at one in two million and can be further reduced by screening procedures. Complications generally result from underlying other pre-existing conditions. I understand that a risk exists.

I am ultimately responsible for my health and therefore may seek care from other related health care fields. Common alternatives to chiropractic treatment consist of acupuncture, massage therapy, physical therapy, and orthopedic evaluation. Each of these have their own risks and benefits. I am free to discuss any questions or concerns with the doctor as the need arises, especially during my first visit. Based this information, I understand the nature of treatment, its risks/benefits, and that other alternatives exist for me to pursue.

I have read this document and give my consent to receive chiropractic treatment. I intend this document to cover the entire course of care, now and in the future, and agree to its provisions.

Patient Name (Printed): _____

Patient or Guardian Signature: _____ Date:_____

Females Only - Regarding Possibility of Pregnancy

X-rays, particularly those involving the lumbopelvic region, can be hazardous to an unborn child. It is advisable that, in women of child-bearing potential, X-rays be taken only in the first ten (10) days following the onset of a menstrual cycle, as this is generally considered to be safe for X-ray exams. With this in mind, I certify that to the best of my knowledge I am NOT pregnant, and the doctor has permission to perform diagnostic X-rays. It it my responsibility to update the treating doctor if this status changes.

Initial:_____

HIPAA - Notice of Privacy Policy

Our Notice of Privacy Practices provides information about how we may use and disclose “protected health information” (PHI) about you. A summary is below, and our full privacy statement is made available on the practice website: www.CompassChiroVA.com.

* Our office does not distribute or make available to any outside source your PHI except in cases of treatment or referrals, claims submission to third party insurance carriers for the purposes of payment, and other health care operations (subpoena of records).
* A family member may be present during your visit, but your PHI will not be available to them without your written authorization.
* Our office may utilize, text, phone, or email reminders to confirm or reschedule an appointment.
* We may leave a voicemail at the phone number provided unless you have specifically instructed us to the contrary.
* You have the right to withdraw consent and terminate care at any time for any reason. Withdrawals of consent must be in writing.

Patient or Guardian Signature: _____ Date:_____

Compass Chiropractic LLC
13146 Midlothian Turnpike
Midlothian, VA 23113
Phone: 804.499.6020
Fax: 804.499.6030

Assignment of Insurance Benefits

I, _____, assign and direct that payment be made directly to:
(Printed Name)

COMPASS CHIROPRACTIC LLC
13146 MIDLOTHIAN TURNPIKE
MIDLOTHIAN, VA 23113

for any and all insurance benefits or reimbursement of services rendered by Compass Chiropractic LLC which amounts would otherwise be payable to me under my insurance or pre-paid health plan.

I further understand that if my insurance carrier mistakenly sends payment to me for services incurred in this office, I agree to surrender those payments upon receipt.

Patient or Guardian Signature: _____ Date:_____

Financial Policy

There is no guarantee that your insurance company or pre-paid health plan will cover or pay for charges you incur. In the event of denied claims, reduction of benefits, or failure of my insurance company to pay for any reason, you are responsible for all remaining charges. This is so even if the results of your treatment are not as expected.

General Information:
All deductibles, co-insurances, and copayments are due at the time of service.
It is your responsibility to notify us of any changes to your health insurance.
Our office will provide whatever treatment is necessary to help your condition or complaint, regardless of what your insurance coverage is or what they consider to be medically necessary. You are responsible for these balances.

Collection Fees: In the event that your account is turned over to a collection agency, you will be responsible for any and all collection costs, include reasonable attorney's fees.

Missed Appointments: Unless cancelled at least 24 hours in advance, our policy assesses a $15 fee for missed appointments and a $30 fee for missed new patient appointments. We strive to have little to no wait time for all visits, and this can only be accomplished if you keep your appointments or provide notice of changes.

I have read, understand, and agree to this financial policy.

Patient or Guardian Signature: _____ Date:_____

Compass Chiropractic LLC

Voluntary Advance Beneficiary Notice (ABN)

To Our Medicare Patients: This document contains important information about what services Medicare does and does not cover when visiting any chiropractic office.

The information in this box refers to chiropractic *adjustments only*.

Deductible

For this year, Medicare requires that you pay an annual Part B deductible of $257 before they will begin paying for covered services. The part B deductible is cumulative across all physician offices, not just chiropractors, but excludes hospitals (Part A) and pharmacy (Part D) costs.

Chiropractic Adjustments

After you have met your deductible, or if your Medicare supplement covers the deductible for you, then Medicare will reimburse 80% of the allowable treatment charges. The other 20%, called the co-insurance, is the patient responsibility, unless the Medicare supplement also covers this, as many do.

X-Rays:

Dr. McDade offers X-ray on-site and may determine X-rays are warranted to properly diagnose and treat your case. Medicare does **not** cover X-rays performed in a chiropractic office.
Our charge is $85 per set of X-rays. A 'set' typically includes 2 views (front and side).

Examinations

All chiropractors are required to perform an intake examination in order to diagnose and provide appropriate treatment. Smaller re-examinations are performed every 30 days during active care, and for returning patients who have been out of the office for over 90 days. Medicare requires, but does **not** cover, these examinations. The intake examination cost is typically $65, and re-exams are $40.

Therapies

This term refers to ancillary services performed in the office and including decompression, heat with electric stim, flexion distraction, and trigger point work. **No therapies are covered by Medicare**. Our charge ranges from $10-$15 per therapy. Most Medicare patients only get 1 per therapy visit.

Maintenance

Once symptoms are resolved, or are not expected to improve with more treatment, Medicare considers the visit to be "maintenance.". This means it is not 'medically necessary' in their eyes and won't be covered. Dr. McDade will alert you when your case approaches this status. To be fair, no insurance covers maintenance visits, the same way auto insurance never pays for routine oil changes.

I, _____ (Printed Name) have read the above notice and understand that I may receive services that are *not* covered by Medicare. My signature indicates I have received the above notice, not that I agree it is fair.

Signature: _____ Date: _____

Compass Chiropractic LLC: Health Profile

Please fill out this form to the best of your ability. All of your information is strictly confidential.

Legal Name: _____ Date: _____

Mailing Address: _____ Occupation: _____

_____ (If retired/unemployed, list former occupation)

Email: _____ Height: _____

Weight: _____lbs

How did you hear about us? _____

Emergency Contact (Required)

Have you been to a chiropractor before? ❑ Yes ❑ No Name: _____

If Yes, was it a good experience? ❑ Yes ❑ No Relationship: _____

Are you nervous about being adjusted? ❑ Yes ❑ No Phone: _____

1. Lifestyle:

Smoking: ❑ 0 Cigarettes/day (non-smoker) ❑ 1-3 Cigarettes/day
❑ 0 Cigarettes/day (former-smoker) ❑ 1-2packs/day ❑ 2+ packs/day

Alcohol: ❑ Abstainer (none at all) ❑ Heavy drinker
❑ Light/Moderate drinker ❑ Former Alcoholic (sober since: _____)

Activity Level: ❑ Sedentary (none) ❑ Moderate activity (jogging)
❑ Light activity (i.e. walking) ❑ Vigorous activity (max exertion)

Any hobbies/sports you participate in regularly? _____

_____

2. Medical History:

Hospitalizations/Surgeries: please check the boxes if you have had any of these particular surgeries.

❑ Spine ❑ Shoulder (R/L) ❑ Brain ❑ Lung ❑ Gallbladder
❑ Hip (R/L) ❑ Knee (R/L) ❑ Heart ❑ Breast ❑ Appendix

Year: _____ Area/reason: _____ Procedure: _____
Year: _____ Area/reason: _____ Procedure: _____
Year: _____ Area/reason: _____ Procedure: _____

Prior Accidents/Injuries: includes car accidents, falls, sports injuries, etc.

Year: _____ Area injured: _____ How? _____
Year: _____ Area injured: _____ How? _____
Year: _____ Area injured: _____ How? _____

Ongoing Condition(s)? ❑ No ❑ Yes, please list: _____

Allergies? ❑ No ❑ Yes, please list: _____

Prescription Medications: If you have a medication list, please give us a copy and skip this section.

Medication	Reason	Date Started

Family History: this pertains to your direct siblings, parents, and grandparents **only**

❑ Cancer ❑ Stroke ❑ RA ❑ Seizures ❑ Diabetes
❑ Thyroid ❑ Heart Attack ❑ Osteoporosis ❑ Blood clots ❑ Kidney Disease

❑ Other: _____

Were there any deaths directly related to the above conditions? ❑ No ❑ Yes (fill in below)

Who _____ Condition _____ Age _____
Who _____ Condition _____ Age _____

Review of Systems: have **you** had a problem, whether now or in the past, with any of the following?

❑ Lethargy/Weakness
❑ Recurring Fever
❑ Recent Weight Loss/Gain
❑ Dizziness/Vertigo
❑ Chills
❑ Headaches
❑ Night Sweats

❑ Cancer
❑ Diabetes (Type I/II)
❑ Excessive Thirst
❑ Frequent Urination
❑ Thyroid Disorders
❑ Heart attack/disease
❑ Blood clots/DVT
❑ Ringing in ears
❑ Asthma/Allergies

❑ Migraines
❑ Memory Loss
❑ Poor Balance
❑ Numbness/Tingling
❑ Seizures
❑ Stroke/TIA
❑ Tremors
❑ Head Trauma
❑ Anxiety
❑ Depression
❑ Sleep Problems
❑ Weak Muscles
❑ Loss of Taste/Vision
❑ Double Vision
❑ Difficulty concentrating
❑ Difficulty controlling urination
❑ Incontinence of bowels

❑ Arthritis
❑ Joint Pain/Swelling
❑ Neck Pain
❑ Back Pain
❑ Trauma
❑ Osteoporosis
❑ Scoliosis
❑ Cramping
❑ Fractures
❑ Implants/Screws/Pins
❑ Hip Disorders
❑ Knee Injuries
❑ Foot/Ankle Pain
❑ Shoulder Problems
❑ Elbow/Wrist Pain
❑ Poor Posture
❑ Gout

Other Medical History:

Any steroid/epidural injections? ❑ No ❑ Yes, part of body: _____ Date: _____

Recent infections/immunizations? ❑ No ❑ Yes, please list: _____

Recent unintentional weight loss? ❑ No ❑ Yes, I've lost about _____ pounds in the last _____

FEMALES ONLY: is there any possibility that you are pregnant? ❑ No ❑ Yes ❑ Unsure

3. Primary Complaint: Please fill out this section in regards to a **single body area** only.

List the **body region only of your #1 problem**: _____

When did this start? _____ ❑ This is a recurring problem for me

What happened? _____ ❑ Started suddenly ❑ Started gradually

This problem is:	❑ Right-sided only	❑ Left-sided only	❑ Both	❑ In the middle
This problem is:	❑ Constant	❑ Frequent	❑ On/Off	❑ Occasional
When present, it lasts:	❑ Days	❑ Hours	❑ Minutes	❑ Seconds

On **average**, the severity of the complaint is: _____ /10 At its **worst**: _____ /10

Describe how it feels: (check all that apply)	❑ Aching	❑ Burning	❑ Dull	❑ Sharp	❑ Stabbing
	❑ Throbbing	❑ Stiffness	❑ Weakness	❑ Numbness	❑ Tingling

This problem is worsened by:			This problem is improved by:		
❑ Activity	❑ Twisting	❑ Lying Down	❑ Cold	❑ Rx Meds	❑ Morning
❑ Bending	❑ Getting Up	❑ Morning	❑ Heat	❑ Rest	❑ Night
❑ Lifting	❑ Everything	❑ Night	❑ Activity	❑ Stretching	❑ Sitting
❑ Standing	❑ Ice	❑ Overhead Reach	❑ Lying down	❑ Support brace	❑ Standing
❑ Stress	❑ Job	❑ Sitting	❑ OTC Meds	❑ Chiropractic	❑ TENS Unit
❑ Temp change	❑ Kneeling	❑ Touch/Pressure	❑ Posture change	❑ Massage	❑ Time off Work

Overall, this problem has been: ❑ Improving ❑ Staying the same ❑ Worsening

Which of these apply to your job? ❑ Prolonged standing ❑ Prolonged sitting ❑ Heavy lifting

Check the box if there is more to your problem than this, and the doctor will ask you about it: ❑ There is more

4. Secondary Complaint: Please fill out this section in regards to a **single body area** only.

List the **body region only of your #2 problem**: _____

When did this start? _____

What happened? _____ ❑ Started suddenly ❑ Started gradually

This problem is:	❑ Right-sided only	❑ Left-sided only	❑ Both	❑ In the middle
This problem is:	❑ Constant	❑ Frequent	❑ On/Off	❑ Occasional
When present, it lasts:	❑ Days	❑ Hours	❑ Minutes	❑ Seconds

On **average**, the severity of the complaint is: _____ /10 At its **worst**: _____ /10

Describe how it feels: (check all that apply)	❑ Aching	❑ Burning	❑ Dull	❑ Sharp	❑ Stabbing
	❑ Throbbing	❑ Stiffness	❑ Weakness	❑ Numbness	❑ Tingling

This problem is worsened by:			This problem is improved by:		
❑ Activity	❑ Twisting	❑ Lying Down	❑ Cold	❑ Rx Meds	❑ Morning
❑ Bending	❑ Getting Up	❑ Morning	❑ Heat	❑ Rest	❑ Night
❑ Lifting	❑ Everything	❑ Night	❑ Activity	❑ Stretching	❑ Sitting
❑ Standing	❑ Ice	❑ Overhead Reach	❑ Lying down	❑ Support brace	❑ Standing
❑ Stress	❑ Job	❑ Sitting	❑ OTC Meds	❑ Chiropractic	❑ TENS Unit
❑ Temp change	❑ Kneeling	❑ Touch/Pressure	❑ Posture change	❑ Massage	❑ Time off Work

Overall, this problem has been: ❑ Improving ❑ Staying the same ❑ Worsening

Which of these apply to your job? ❑ Prolonged standing ❑ Prolonged sitting ❑ Heavy lifting

Check the box if there is more to your problem than this, and the doctor will ask you about it: ❑ There is more

5. Other:

Optional: Describe any goal, expectations, or reservations you have at this time.

_____

_____

_____

I have read and completed the above information and certify it to be true to the best of my knowledge. I hereby permit this office to use my responses to provide me with chiropractic care, according to the state's regulations.

Patient Name (printed): _____

Signature of Patient/Guardian: _____ Date: _____

6. Doctor's Notes: Patients Leave Blank

BP: _____ Pulse: _____

1° _____ MOI: _____ 2° _____ MOI: _____

Notes: _____

_____

_____

❑ Painful SST ❑ Normal CLC ❑ Normal NSM

Codes: ❑ 98940 ❑ 98941 ❑ 98943 ❑ 72040 ❑ 72100 ❑ 72110 ❑ 99202 ❑ 99203 ❑ 97012 ❑ 97014

TP: ❑ 8 ❑ 16 ❑ 24 ❑ PPV ❑ MWP ❑ CNB12 ❑ Actiflex

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short -form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.