

Chiropractic Registration and History

1 Patient Information

Date: _____
 Patient: _____
 Address: _____
 City _____ State _____ Zip _____
 Sex: M F Age: _____ Birth Date: ____/____/____
 Single Married Widowed Separated Divorced
 Patient SS#: _____
 Occupation: _____
 Employer: _____
 Employer Address: _____
 Employer Phone: _____
 Spouse's Name: _____
 Birth Date: ____/____/____ -SS#: ____-____-____
 -Occupation: _____
 -Employer: _____
 Whom may we thank for referring you? _____

2 Insurance

Who is responsible for the account? _____
 Relationship to patient: _____
 Insurance Co.: _____
 Group #: _____
 Is patient covered by additional insurance? Yes No
 Subscribers Name: _____
 Birth Date: ____/____/____ SS#: ____-____-____
 Relationship to patient: _____
 Insurance Co.: _____
 Group #: _____
ASSIGNMENT AND RELEASE
 I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Back in Line Chiropractic Center Inc., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Back in Line Chiropractic Center Inc. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Also, Payment Now fees are to be paid at time of service.
 Responsible Party Signature _____
 Relationship _____ Date _____

3 Phone Numbers

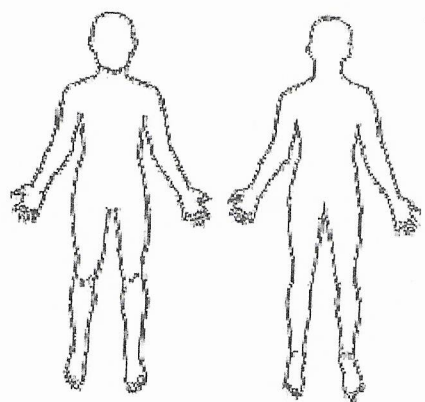
Home: _____ Work: _____
 -Ext.: _____
 Cell Phone: _____
IN CASE OF EMERGENCY CONTACT:
 Name: _____ Relationship: _____
 Phone Number: _____

4 Accident Information

Is condition due to an accident? Yes No
 Date: ____/____/____
 Type of Accident: Auto Work Home Other _____
 To whom have you made a report of your accident?
 Auto Insurance Employer Worker Comp. Other _____
 Attorney Name (if applicable) _____

5 Patient Condition

What is your major symptom/problem? _____
 When did the symptoms appear? _____
 Is this condition getting progressively worse? Yes No Unknown
 Have you noticed any visceral or neurological problems since the condition occurred?
 (For example: High blood pressure, loss of balance, numbness, etc.) _____
Mark an X on the picture where you continue to have pain, numbness, or tingling.
 Rate the severity of the pain on a scale from 1 (least pain) to 10 (most pain)
Type of pain: Sharp Dull Throbbing Numbness Aching Radiating
 Shooting Burning Tingling Cramps Stiffness Swelling
 Other _____
 How Often do you have the pain? _____
 Is it constant or does it come and go? _____
 Does it Interfere with your? Work Sleep Daily Routine Recreation
 What makes your condition better? _____
 What makes your condition worse? _____
 Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down _____
 Is there a particular time of day that your problem is better or worse? _____



Patient Medical History

Back in Line Chiropractic Center

Name: _____ Date: _____

List any surgery(s) and dates: _____

List any falls or accidents: _____

Broken bones, dislocations or fractures: _____

Were you ever knocked unconscious? Yes No

Do you suffer from any condition(s) other than that for which you are consulting us? _____

Are you presently taking any medication, prescription or over the counter? _____

Do you have any allergies? _____

When did you last see a chiropractor? _____ Dr. _____

Please indicate conditions you have by marking below with (X), conditions you have had in the past with (O), and family history of conditions with (F):

- | | | | |
|------------------------------------|---------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Polio | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Multiple Sclerosis |

PLEASE CHECK ALL PRESENT SYMPTOMS:

CARDIOVASCULAR

- general swelling
- loss of coordination
- swelling in face
- chest pain
- rapid heart beat
- blue or purple skin
- blue or purple nailbeds
- fainting
- ringing in ears
- heart attack
- high blood pressure
- irregular heart beat
- hardening of the arteries
- dizziness with nausea
- blurred vision
- fainting spells
- stroke
- diabetes
- cold hands and/or feet
- area of numbness
- arthritis of the neck
- previous neck or head injury
- loss of memory
- periods of blindness in one eye
- check if any of your family members have had a stroke

VERTEBROSILAR

- double vision
- pain across shoulders
- irregular muscle movement

MUSCULARSKELETAL SYSTEMS/HEAD

- unusually frequent headache
- unusually severe headache
- head feels heavy
- vertigo
- light-headedness
- loss of smell
- loss of taste
- loss of balance
- dizziness

NECK

- pain in neck
- neck pain with movement
- swelling in neck
- pinched nerve in neck
- neck out of place
- muscle spasms in neck
- grinding sounds in neck
- popping sounds in neck
- stiff neck
- limited neck movement

SHOULDERS

- pain in shoulders (right) (left)
- swelling in legs
- tension in shoulders
- muscle spasms in shoulder
- can't raise arm (right) (left)

ARM AND HANDS

- pain in upper arm
- pain in forearm
- pain in hands or fingers
- sensation of pins and needles in arms or fingers
- fingers fall asleep
- hands cold
- swollen joints in fingers
- sore joint in fingers
- loss of grip strength

MID BACK

- mid back pain
- pain between shoulder blades
- pain from front to back
- pain over kidney area
- muscle spasms in mid back

LOW BACK

- low back pain
- low back feels out of place
- muscle spasms in low back

HIPS, LEGS, AND FEET

- pain in buttocks
- pain down leg
- knee pain
- leg cramps
- pins and needles in legs
- numbness in leg or toes
- cold feet
- swollen ankles or feet

SKIN HAIR NAIL

- eczema
- itchy skin
- dry scalp
- oily scalp
- rough, scaly skin
- dry skin
- oily skin
- psoriasis
- yellow skin
- bruise easily
- paper thin nails
- hair loss

EYES

- blurring of vision
- double vision
- eyes fatigue easily
- excessive tearing
- lack of tearing
- light bothers eyes
- excessive itching
- pain in eyeball

EARS

- loss of hearing
- pain in ears
- discharge from ears
- vertigo
- ringing in ears

NOSE NASOPHARYNX

- unusual nasal discharge
- nose bleeds
- pressure over eyes
- pressure under eyes
- obstruction in nose
- frequent colds
- sinusitis
- nasal allergies
- loss of sense of smell
- any trauma to nose

MOUTH AND THROAT

- cavities
- pain in mouth
- pain in throat
- bleeding gums
- difficulty swallowing
- changes in voice

RESPIRATORY

- shortness of breath
- dry cough
- productive cough
- coughing up blood
- wheezing

GASTROINTESTINAL

- poor appetite
- indigestion
- can't eat some foods
- nausea and vomiting
- abdominal pain
- change in bowel habits
- diarrhea
- constipation
- hemorrhoids

WOMEN ONLY

- painful period
- spotting
- vaginal discharge
- premenstrual symptoms
- irregular periods
- lumps in breast
- take birth control pills
- # of pregnancies: _____
- # of deliveries: _____

GENITOURINARY

- urination
- frequents
- normal
- infrequent
- low
- need to get up at night to urinate
- abnormal intense desire to urinate
- difficulty starting urination
- decreased output
- pain on urinating
- dribbling
- blood in urine
- cloudy urine
- lack of bladder control

VENERAL DISEASE

- AIDS
- syphilis
- gonorrhea

SOCIAL HISTORY

- smoking
- other tobacco use
- alcohol use
- drink coffee or tea

diet is: balanced
 not balanced

rest is: sufficient
 not sufficient

recreation is: sufficient
 not sufficient

my stress level is: severe
 moderate
 minimal
 none

GENERALLY FEEL

- nervousness
- irritability
- fatigue

**Patient Consent for Use and Disclosure
of Protected Health Information**

Back in Line Chiropractic Center

I hereby give consent for Back in Line Chiropractic Center to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations. (TPO)

Back in Line Chiropractic Center's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have read Back in Line Chiropractic Center's Notice of Privacy Practices prior to signing this consent. Back in Line Chiropractic Center reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Back in Line Chiropractic Center, 6991 W. Broward Blvd. #107, Plantation, FL 33317.

With this consent, Back in Line Chiropractic Center may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Back in Line Chiropractic Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as there marked Personal and Confidential.

With this consent, Back in Line Chiropractic Center may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Back in Line Chiropractic Center restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Back in Line Chiropractic Center's use and disclosures of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Back in Line Chiropractic Center may decline to provide treatment to me.

Signature of Patient or Legal guardian

Patient's Name (print)

Date

Print Name of Patient or Legal Guardian

Informed Consent of Chiropractic Treatment

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular, you should note:

- a) While rare, some patients may experience short-term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques.
- b) There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes some neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote.
- c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused or may be caused by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches, and other similar symptoms.

Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss with my chiropractor the nature and purpose or chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____ 20_____

Patient Signature (or Legal Guardian)

Signature of Witness

Patient Name (printed)

Witness Name (printed)

Prior Chiropractic Treatment Information

Name of Chiropractor: _____

Location: _____

When was your last treatment? _____

Have you had X-rays? _____

Notice to Patients

Please note that all x-rays are analyzed for alignment and possible fractures at the time of the initial Report of Findings. A final analysis review will also be conducted by the physician upon their convenience; at which, the findings will be disclosed to the patient. Should the physician locate any matter which may be out of their scope of practice, the x-rays will be sent out to be analyzed and reported on by an independent radiologist for a service fee of \$35.00. The patient will be responsible for this fee.

Additionally, if patient prefers to have the final analysis conducted sooner, the x-rays may be sent out to be analyzed and reported on by an independent radiologist for a service fee of \$35.00. The patient will be responsible for this fee.

____ Yes, I would prefer my x-rays sent out immediately for final analysis for a fee of \$35

Patient Signature

Date

Patient Name

**ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient Name (please print)

Date

Parent, Guardian or Patient's legal representative

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____	_____
_____	_____
_____	_____

**ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below I authorize being contacted for practice reminders by:

Mail _____;
Email _____; at email address _____;
Telephone numbers _____;

By voice mail _____;
By text message _____;
By FaceBook address _____.

By checking this checking the lines below I authorize being contacted for birthday greetings or promotions about the practice by:

Mail _____;
Email _____ at email address _____;
Telephone numbers _____;

By voice mail _____;
By text message _____;
By FaceBook address _____.

By checking this checking the lines below I authorize the doctor to personally discuss with me products that may benefit my health or condition. _____

Patient Name (please print)

Date

Name of Parent, Guardian or Patient's legal representative

Signature of Patient, Parent, Guardian or Patient's legal representative

ADVANTAGE RADIOLOGY SERVICE

(419) 269-2424

(844) 283-4163

PATIENT _____ CLINIC _____ FILM DATE _____
AGE _____ SEX M F SOCIAL SECURITY # _____ / _____ / _____ DATE OF BIRTH _____
PATIENT ADDRESS _____ CITY _____ STATE _____ ZIP _____

X-RAY ASSIGNMENT AGREEMENT

I understand that the services of a chiropractic radiologist are being utilized to insure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the clinic where I am receiving care, and that the charges for these services will be submitted to my insurance carrier, Workers' Compensation carrier or State Bureau, and/or to my attorney in the case of personal injury.

In the event that I receive payment for these services, I agree to promptly remit payment to Advantage Radiology Service (ARS).

I assign my insurance benefits and rights to payment to ARS to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company, attorney, and/or any third-party payer. I authorize my treating physician, insurance company, attorney, and/or any third-party payer to provide ARS or their agents with any information concerning my claim, their services, and/or payment for the services provided.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.

SIGNATURE: _____

DATE: _____

WITNESS: _____

PATIENT HISTORY

PATIENT PRESENTATION _____

TRAUMA? YES NO EXPLAIN _____

PAST MEDICAL HISTORY _____

MALIGNANCY? YES NO DETAILS _____

DIAGNOSIS/CONCERNS/QUESTIONS [NO ICD CODES PLEASE] _____

PLEASE COMPLETE INSURANCE/BILLING INFO ON REVERSE SIDE

ADVANTAGE RADIOLOGY SERVICE

(419) 269-2424

(844) 283-4163

CASH (no insurance) _____ MEDICARE ONLY _____ MEDICAID ONLY _____

STANDARD

NEED NON-PARTICIPATING PROVIDER INSURANCE NAME & BILLING ADDRESS

**PLEASE ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD(S).*

INSURANCE NAME & BILLING ADDRESS (PRIMARY)				INSURANCE NAME & BILLING ADDRESS (SECONDARY)					
CARRIER		TELEPHONE		CARRIER		TELEPHONE			
ADDRESS				ADDRESS					
CITY		STATE	ZIP	CITY		STATE	ZIP		
RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER _____				RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER _____					
INSURED NAME		INSURED DATE OF BIRTH		INSURED NAME		INSURED DATE OF BIRTH			
INSURED SOCIAL SECURITY #		INSURED ID #		INSURED SOCIAL SECURITY #		INSURED ID #			
INSURED GROUP #		BCBS 3 LTR PREFIX		INSURED GROUP #		BCBS 3 LTR PREFIX			
INSURED EMPLOYER		TELEPHONE		INSURED EMPLOYER		TELEPHONE			
IF W/C: EMPLOYER ADDRESS		CITY	ST	ZIP	IF W/C: EMPLOYER ADDRESS		CITY	ST	ZIP

AUTO ACCIDENT/PI/WORKERS' COMPENSATION

RELATIONSHIP TO EMPLOYMENT? YES NO AUTO ACCIDENT? YES NO
OTHER? YES NO

CLAIM # _____

DATE OF INJURY _____

W/C CARRIER or AUTO INSURANCE			NAME & BILLING ADDRESS <small>LIST BOTH LIABILITY & MED PAY CARRIERS (USE ADDITIONAL PAPER IF NECESSARY)</small>			ATTORNEY NAME & BILLING ADDRESS		
CARRIER		TELEPHONE		ATTORNEY NAME		TELEPHONE		
INSURANCE ADDRESS						ATTORNEY ADDRESS		
CITY		STATE	ZIP	CITY		STATE	ZIP	
RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER _____						* PLEASE LIST BOTH LIABILITY AND MED PAY CARRIERS USE ADDITIONAL PAPER IF NECESSARY		
INSURED NAME		INSURED SOCIAL SECURITY #						
IF PI: ADJUSTER'S NAME			ADJ. TELEPHONE			IF W/C: ALLOWED DIAGNOSIS ICD-9 CODES		

PLEASE COMPLETE PATIENT HISTORY ON REVERSE SIDE

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____ Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE	X	(Date)
(Or Patient Representative)		
OFFICE SIGNATURE	X	(Date) (Indicate relationship if signing for patient)

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE	X	(Date)
(Or Patient Representative)		(Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

THE REVISED OSWESTRY LOW BACKPAIN QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

Please read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your every day activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST CIRCLE THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1- Pain Intensity

- A. The pain comes and goes and is very mild.
- B. The pain is mild and does not vary much.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain is severe and does not vary much.

SECTION 2- Personal Care

- A. I do not have to change my way of washing or dressing in order to avoid pain.
- B. I do not normally change my way of washing or dressing even though it causes some pain.
- C. Washing and dressing increases the pain but I manage not to change my way of doing it.
- D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- E. Because of the pain I am unable to do some washing and dressing without help.
- F. Because of the pain I am unable to do any washing or dressing without help.

SECTION 3- Lifting

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights but it causes extra pain.
- C. Pain prevents me from lifting heavy weights off the floor.
- D. Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table.
- E. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- F. I can only lift very light weight at the most.

SECTION 4- Walking

- A. I have no pain when I walk.
- B. I have some pain when I walk but it does not increase with distance.
- C. I cannot walk more than 1 mile without increasing pain.
- D. I cannot walk more than ½ mile without increasing pain.
- E. I cannot walk ¼ mile without increasing pain.
- F. I cannot walk at all without increasing pain.

SECTION 5- Sitting

- A. I can sit in any chair as long as I like.
- B. I can sit only in my favorite chair as long as I like.
- C. Pain prevents me from sitting more than 1 hour.
- D. Pain prevents me from sitting more than ½ hour.
- E. Pain prevents me from sitting more than 10 minutes.
- F. I avoid sitting because it increases pain immediately.

SECTION 6- Standing

- A. I can stand as long as I want without pain.
- B. I have some pain on standing but it does not increase with time.
- C. I cannot stand for longer than 1 hour without increasing pain.
- D. I cannot stand for longer than 12 hour without increasing pain.
- E. I cannot stand for longer than 10 minutes without increasing pain.
- F. I avoid standing because it increases the pain immediately.

SECTION 7- Sleeping

- A. I get no pain in bed.
- B. I get pain in bed but it does not prevent me from sleeping well.
- C. Because of pain my normal night's sleep is reduced by less than $\frac{1}{4}$.
- D. Because of pain my normal night's sleep is reduced by less than $\frac{1}{2}$.
- E. Because of pain my normal night's sleep is reduced by less than $\frac{3}{4}$.
- F. Pain prevents me from sleeping at all.

SECTION 8- Social Life

- A. My social life is normal and gives me no pain.
- B. My social life is normal but increases pain.
- C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- D. Pain has restricted my social life and I do not go out very often.
- E. Pain has restricted my social life to home.
- F. Because of pain I have hardly any social life.

SECTION 9- Travel

- A. I get no pain while travelling.
- B. I get some pain while travelling but none of my usual forms of travel make it worse.
- C. I get extra pain while travelling but it does not compel me to seek alternative forms of travel.
- D. I get extra pain while travelling which compels me to seek alternative forms of travel.
- E. Pain restricts all forms of travel.
- F. Pain prevents all forms of travel except that done lying down.

SECTION 10- Changing Degree of Pain

- A. My pain is rapidly getting better.
- B. My pain fluctuates but overall is getting better.
- C. My pain seems to be getting better but improvement is slow.
- D. My pain is neither getting better nor worse.
- E. My pain is gradually worsening.
- F. My pain is rapidly worsening.

SIGNATURE: _____

SCORE: _____

Patient Name _____ Date _____

Neck Disability Index

This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and **mark in each section only the one box that applies to you**. We realize you may consider that two or more statements in any one section relates to you, but please just mark the box that most closely describes your problem.

Section 1: Pain Intensity

- I have no pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

Section 2: Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain
- I can look after myself normally but it causes extra pain
- It is painful to look after myself and I am slow and careful
- I need some help but can manage most of my personal care
- I need help every day in most aspects of self care
- I do not get dressed, I wash with difficulty and stay in bed

Section 3: Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives extra pain
- Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on the table
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- I can only lift very light weights
- I cannot lift or carry anything

Section 4: Reading

- I can read as much as I want to with not pain in my neck
- I can read as much as I want to with slight pain in my neck
- I can read as much as I want with moderate pain in my neck
- I can't read as much as I want because of moderate pain in my neck
- I can hardly read at all because of severe pain in my neck
- I cannot read at all

Section 5: Headaches

- I have not headaches at all
- I have slight headaches, which come infrequently
- I have moderate headaches, which come infrequently
- I have moderate headaches, which come frequently
- I have severe headaches, which come frequently
- I have headaches almost all the time

Patient Name _____ Date _____

Section 6: Concentration

- I can concentrate fully when I want to with no difficulty
- I can concentrate fully when I want to with slight difficulty
- I have a fair degree of difficulty in concentrating when I want to
- I have a lot of difficulty in concentrating when I want to
- I have a great deal of difficulty in concentrating when I want to
- I cannot concentrate at all

Section 7: Work

- I can do as much work as I want to
- I can only do my usual work, but no more
- I can do most of my usual work, but not more
- I cannot do my usual work
- I can hardly do any work at all
- I can't do any work at all

Section 8: Driving

- I can drive my car without any neck pain
- I can drive my car as long as I want with slight pain in my neck
- I can drive my car as long as I want with moderate pain in my neck
- I can't drive my car as long as I want because of moderate pain in my neck
- I can hardly drive at all because of severe pain in my neck
- I can't drive my car at all

Section 9: Sleeping

- I have no trouble sleeping
- My sleep is slightly disturbed (less than 1 hr sleepless)
- My sleep is mildly disturbed (1-2 hrs sleepless)
- My sleep is moderately disturbed (2-3 hrs sleepless)
- My sleep is greatly disturbed (3-5 hrs sleepless)
- My sleep is completely disturbed (5-7 hrs sleepless)

Section 10: Recreation

- I am able to engage in all my recreation activities with not neck pain at all
- I am able to engage in all my recreation activities, with some pain in my neck
- I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
- I am able to engage in a few of my usual recreation activities because of pain in my neck
- I can hardly do any recreation activities because of pain in my neck
- I can't do any recreation activities at all

Score ___/50 Transform to percentage score x 100 = ___% points

Scoring: For each section the total possible score is 5: if the first statement is marked the section score = 0, if the last statement is marked it = 5. If all ten sections are completed the score is calculated as follows: Example: 16 (total scored)

50 (total possible score) x 100 = 32%

If one section is missed or not applicable the score is calculated: 16 (total scored)

45 (total possible score) x 100 = 35.5%

Minimum Detectable change (90% confidence); 5 points or 10% points

NDI developed by: Vernon, H. & Mior, S. (1991). The Neck Disability Index: A study of reliability and validity. Journal of Manipulative and Physiological Therapeutics. 14, 409-415.

(A) Notifier(s): Back In Line Chiropractic Center
 6991 W. Broward Blvd., Ste. 107, Plantation, FL 33317 (954)584-2225

(B) Patient Name:

(C) Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for (D) (Multiple items) below, 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 the (D) _____ below.

(D) Multiple Items	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:
Examination X-Rays Extremity Adjustment Massage Therapies (Trigger Point, Traction, Laser, Stretches, Rehab Exercises, Supplies) Acupuncture	Not a statutorily covered charge	Exam: \$200-250 X Rays: \$40/x-ray Extremity Adj: \$70 Therapies: \$60-75 Massage: \$75/30 mins, \$150/60 mins Acupuncture: \$85-\$120

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 (D) _____ listed above.

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 the (D) _____ listed above. 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 the (D) _____ listed above, 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 the (D) _____ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

(H) Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(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 estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.