Southern Maryland Chiropractic Center

Chiropractic & Physical Therapy

3450 Old Washington Road, Ste. 101, Waldorf, MD20602
Tel: 301-638-7300 SoMdChiro@yahoo.com

To our valued patient,

Welcome to Southern Maryland Chiropractic Center. We would like to take this opportunity to thank you for choosing our chiropractic practice as your wellness provider. It is our goal to become your partner in health and provide quality care that will bring your natural state of wellness that you want and deserve.

As a new patient we want to make you feel acquainted with our clinic's procedures and protocols prior to your first visit. The information provided below explicitly outlines, explains, and answers the policies of our clinic.

New Patient Registration

Prior to your first appointment, please download and complete the packet of *New Patient forms* available on our website. If you are unable to download or print our registration packet, we can provide you with the paperwork at your appointment time. Please also bring a form of I.D. and your insurance card.

Office Hours and Making an Appointment

Our office hours are Monday, Wednesday, and Thursdays *by appointment only.* To schedule an appointment please call (301)-638-7300 or submit an appointment request on our website. Once a request is made, please wait for a confirmation date and time from our Front Office Administrator.

Cancelling and Rescheduling an Existing Appointment

Cancellations must be made at least 24-hours prior to your scheduled appointment time. If you know you will not be able to keep your appointment time please contact our office as soon as possible, either by text or phone. Our automated text messaging system will send out 24-hour and 2-hour reminders directly to your phone before your appointment. This system conveniently allows you to directly communicate with our Front Office Administrator for any changes related to appointments.

Office Protocols

- Only patients are allowed in the clinic, unless a minor is being accompanied by a guardian.
- Patients are scheduled in 5-minute increments, please arrive exactly on time. If you are early do not enter the clinic, please wait until your designated appointment time. If more than 5 minutes late, also do not enter the clinic. Please call/ text our Front Office Administrator and we will try to make accommodations for you.
- If you have a new condition or concern, please inform our Front Office Administrator prior to seeing Dr. Kane. This ensures that we can designate special time outside of the adjustment hours for a clinical update.

Waiting Time

At Southern Maryland Chiropractic we understand that your time is valuable. Our goal is to not have patients wait. We will try to be efficient and courteous of your time, but given our unique and genuine patient care philosophy sometimes situations occur that develop a short wait time.

Cell Phone Use

As a courtesy to others, we request that you turn off or silence cellular devices and refrain from using them while within our clinic. These areas include the waiting room, adjusting rooms, and therapy area. If you need to take a phone call you may step outside our clinic to the main hall of the building.

Billing and Insurance Information

Billing, account balances, and insurance information are handled by our outside billing company *Healthcare Data Management.* We will verify your insurance benefits as a courtesy to you, but ultimately it is the patient's responsibility to understand their health insurance benefits.

Thank you for understanding our clinic's procedures and policies as listed above. Once again welcome to our family practice!
Sincerely,
The Southern Maryland Chiropractic Center Team

By signing this form you are in agreement with all of the following information outlined above. If you have any questions regarding our procedures and policies feel free to call our office.

Patient Signature: ______________________________

SOUTHERN MARYLAND CHIROPRACTIC CENTER

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

________________________________ ____________________________

Name of Patient: (print & sign) Date:

3450 Old Washington Road, Ste 101, Waldorf, Maryland 20602

SOUTHERN MARYLAND CHIROPRACTIC CENTER

Patient Registration Form

Confidential Patient Health Record

Name: ______________________________

Street: ______________________________

City: ______________ State: ________ Zip: __________

Cell Phone #: (   ) ______________________

E-Mail Address: ______________________________

Birth Date: ______________ Age: _______ Sex: ______

Marital Status: S M D W

Present Family Doctor: ______________________________

How did you hear about our office?

____

____

____

Employment Information

Employer: ______________________________

Address: ______________________________

City: ______________ State: ________ Zip: __________

Phone #: (   ) ______________________

Occupation: ______________________________

Can our office contact you at work? Yes No

Emergency Contact Information

Emergency Name: ______________________________

Relationship: ______________________________

Phone #: (   ) ______________________

Method of Payment

Check one: Cash ☐ Insurance ☐ Check ☐ Card ☐

Our Policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office manager.

"I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself – not between my insurance company and this office. I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports and forms to my insurance company or attorney to assist in collecting due fees. If mine is a regular health insurance case, I agree to pay a percentage of services as they are rendered. However, I understand that I am ultimately responsible for payment in full at this office."

"I authorize the use of this signature on all insurance submissions."

Patient's Signature: ______________________________ Date: ______________

Authorizing Guardian Signature: ______________________________ Date: ______________

SOUTHERN MARYLAND CHIROPRACTIC CENTER

Patient Complaint Form

Patient Name:______________________________ **Date:**______________________________

Primary Complaint______________________________

Date when symptom first appeared______________________________

How often do you experience the symptoms?

Constant____ Frequent____ Occasional____ Rare ______

Is this related to an accident of fall? Yes____ No____

Is this condition getting progressively worse? Yes____ No____

What makes symptoms increase? ______________________________

What gives relief of symptom? ______________________________

Type of pain:

Sharp____ Dull____ Throbbing____

Numbness____ Aching____ Shooting____

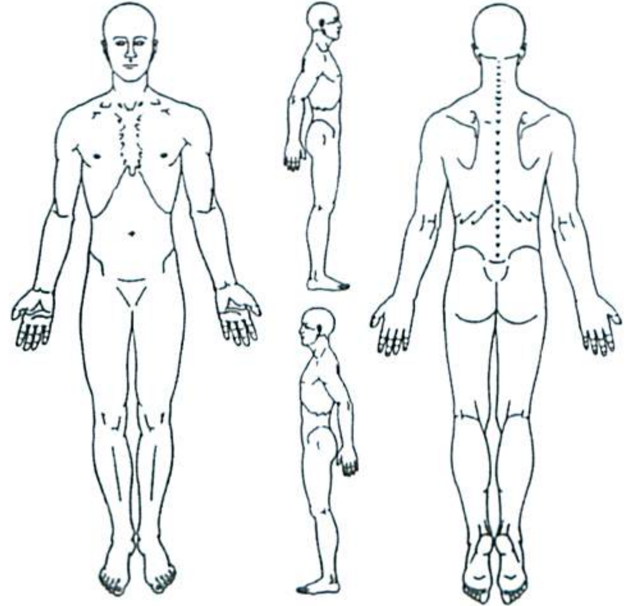
Stiffness____ Swelling____ Tingling____

Does the pain radiate? Yes____ No____

Where? ______________________________

How severe is your pain? *(Please circle a number on the scale below)*

Mark your primary area of pain or discomfort on the figures below



Secondary Complaint______________________________

Date when symptom first appeared______________________________

How often do you experience the symptoms?

Constant____ Frequent____ Occasional____ Rare ______

Is this related to an accident of fall? Yes____ No____

Is this condition getting progressively worse? Yes____ No____

What makes symptoms increase?______________________________

What gives relief of symptom?______________________________

Type of pain:

Sharp____ Dull____ Throbbing____

Numbness____ Aching____ Shooting____

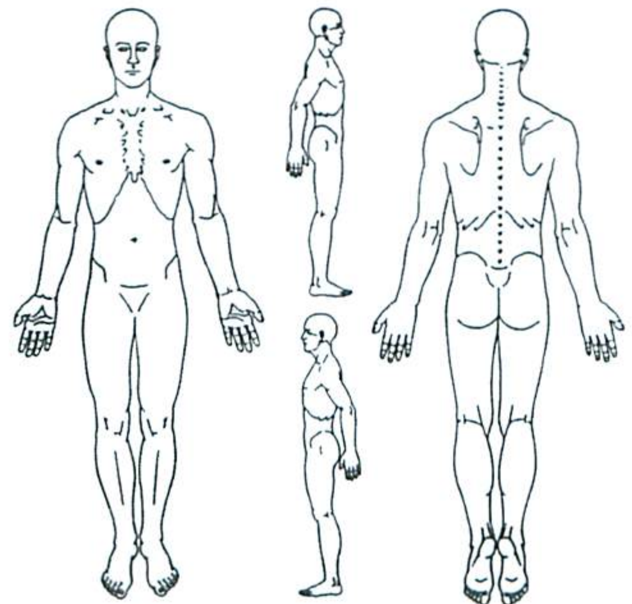
Stiffness____ Swelling____ Tingling____

Does the pain radiate? Yes____ No____

Where? ______________________________

How severe is your pain? *(Please circle a number on the scale below)*

Mark your secondary area of pain or discomfort on the figures below



SOUTHERN MARYLAND CHIROPRACTIC CENTER

Patient Condition History Form

Patient Name: ______________________ **Date:** ______________________

What treatment have you previously received in relation to these present complaints?

- [ ] None
- [ ] Chiropractic Services
- [ ] Surgery
- [ ] Medication
- [ ] Physical Therapy
- [ ] Other: ______________________

Please list each healthcare provider/s you have seen for these present complaints.

Name: ______________________
Location: ______________________
Specialty: ______________________
Date of Care: ______________________
Treatment: ______________________
Results:
____
____

Name: ______________________
Location: ______________________
Specialty: ______________________
Date of Care: ______________________
Treatment: ______________________
Results:
____
____

Name: ______________________
Location: ______________________
Specialty: ______________________
Date of Care: ______________________
Treatment: ______________________
Results:
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Name: ______________________
Location: ______________________
Specialty: ______________________
Date of Care: ______________________
Treatment: ______________________
Results:
____
____

SOUTHERN MARYLAND CHIROPRACTIC CENTER

Patient Health History I

Patient Name:_________________________ **Date:**_________________________

PLEASE LIST SURGERIES YOU HAVE HAD:

Type	Year

PLEASE LIST PREVIOUS ACCIDENTS AND FALLS:

Type	Year

PLEASE LIST PREVIOUS FRACTURES AND DISLOCATIONS:

Type	Year

PLEASE LIST ANY MEDICATIONS AND/OR VITAMINS YOU TAKE:

Type	Frequency

PLEASE LIST ANY ALLERGIES (FOOD / MEDICATION):

Type	Frequency

Occupation Information

Occupation:_________________________

Physical Activity at Work: Sedentary______ Light Manual Labor______ Manual Labor______ Heavy Manual Labor______

Do any of your work activities aggravate your present main complaints? Please describe

____

____

____

SOUTHERN MARYLAND CHIROPRACTIC CENTER

Patient Health History II

Patient Name:____________________ **Date:**____________________

Please CHECK the box below next to the symptoms that apply most to your current health condition. For symptoms that concern or bother you the most please CIRCLE.

Head

- ☐ Headaches
- ☐ Sinus
- ☐ Light-headedness
- ☐ Loss of memory
- ☐ Fainting
- ☐ Blurred vision
- ☐ Double Vision
- ☐ Loss of Vision
- ☐ Dizziness
- ☐ Ringing in ears
- ☐ Buzzing in ears
- ☐ Pain in ears

Neck

- ☐ Pain in neck
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasm in neck
- ☐ Grinding or popping sound

Shoulders

- ☐ Pain in shoulder joint (R / L)
- ☐ Pain across shoulders
- ☐ Difficulty in starting
- ☐ Bursitis (R / L)
- ☐ Muscle spasm in shoulders
- ☐ Tension in shoulders

Arms & Hands

- ☐ Pain in arm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Tingling
- ☐ Numbness
- ☐ Joint Pain

Back

- ☐ Upper back pain
- ☐ Mid back pain
- ☐ Low back pain
- ☐ Muscle pain

Abdomen

- ☐ Nervous stomach
- ☐ Gas
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Urinary Frequency
- ☐ Constipation

Chest

- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Rib pain
- ☐ Irregular heartbeat
- ☐ Breast pain
- ☐ Heart conditions

Hips, Legs & Feet

- ☐ Pain in buttocks
- ☐ Pain in hip
- ☐ Pain down leg
- ☐ Knee pain
- ☐ Leg cramps
- ☐ Numbness in legs
- ☐ Numbness in feet

Women Only

- ☐ Menstrual pain
- ☐ Irregularity
- ☐ Hysterectomy
- ☐ Genital cancer
- ☐ Discharge
- ☐ Menopause
- ☐ Tumors

Men Only

- ☐ Night urination
- ☐ Prostate pain/ swelling

General: CHECK any of the following that you experience.

- ☐ Diabetes
- ☐ Heart Attack/Disease
- ☐ Cancer
- ☐ Stroke
- ☐ Ulcers
- ☐ Aids/HIV
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Tuberculosis
- ☐ Arthritis
- ☐ Thyroid problems
- ☐ Kidney problems
- ☐ Asthma
- ☐ Epilepsy/convulsions
- ☐ Insomnia

Please list any other health conditions not mentioned above____________________