New Patient Intake Forms

Today's Date: _____

curis FUNCTIONAL HEALTH
COUNSELING • CHIROPRACTIC • NUTRITION

PATIENT DEMOGRAPHICS

Name: _____ Birthdate: _____-_____-_____ Age: _____ ○ Male ○ Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

E-mail Address: _____ Marital Status: ○ Single ○ Married Do you have insurance? ○ Yes ○ No

Insurance Company: _____ Primary Insured Name: _____ DOB: _____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Number of children and ages: _____

Name & Number of Emergency Contact: _____ # _____Relationship: _____

Who can we thank for referring you? _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary: _____ Third: _____ Fourth: _____

On a scale of **0** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number*****:**

Primary or chief complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____ When is the problem at its worst? ○ AM ○ PM ○ mid-day ○ late PM

How long does it last? ○ It is constant **OR** ○ I experience it on and off during the day **OR** ○ It comes and goes throughout the week

How did the injury happen? _____

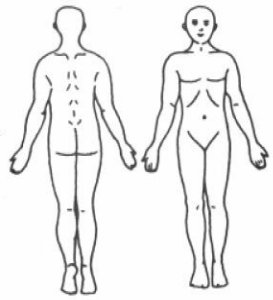
Condition(s) ever been treated by anyone in the past? ○ No ○ Yes **If yes,** when? _____ by whom? _____

How long were you under care? _____ What were the results? _____

Name of previous chiropractor: _____ ☐ **N/A**

PLEASE MARK the areas on the body diagram with the following **letters** to describe your symptoms:

R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling



What relieves your symptoms? _____

What makes your symptoms feel worse? _____

LIST RESTRICTED ACTIVITY	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____	_____	_____
_____	_____	_____

Is your problem the result of ANY type of accident? ○ Yes ○ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ○ No ○ Yes **If yes,** how many times? _____ When was the last episode? _____ How did the injury happen?

_____

Other forms of treatment tried: ○ No ○ Yes **If yes,** please state what type of treatment:
_____, and who provided it? _____ How long ago? _____
What were the results. ○ Favorable ○ Unfavorable Please explain:

_____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with:

P for in the ***Past*** **C** for ***Currently*** have **N** for ***Never*** have had

___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___ Disability ___ Cancer
___ Heart Attack ___ Osteo Arthritis ___ Diabetes ___ Cerebral Vascular ___ Other serious conditions:

_____

PLEASE IDENTIFY ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	**TYPE OF CARE**	**PROVIDED BY WHOM**
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ○ No ○ Yes **If yes,** whom?
○ grandmother ○ grandfather ○ mother ○ father ○ sister(s) ○ brother(s) ○ son(s) ○ daughter(s)
Have they ever been treated for their condition? ○ No ○ Yes ○ I don't know

2. Any other hereditary conditions the doctor should be aware of? ○ No ○ Yes:

_____

SOCIAL HISTORY

1. Smoking: ○ cigars ○ pipe ○ cigarettes How often? ○ Daily ○ Weekends ○ Occasionally ○ Never
2. Alcoholic Beverage: consumption occurs ○ Daily ○ Weekends ○ Occasionally ○ Never
3. Recreational Drug use: ○ Daily ○ Weekends ○ Occasionally ○ Never
4. Hobbies - Recreational Activities - Exercise Regime: How does your present problem affect? (See ADL form)

I hereby authorize payment to be made directly to Flower Mound Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Flower Mound Chiropractic for any and all services I receive at this office.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

REVIEW OF SYSTEMS

Please mark: **P** for in the **Past** **C** for **Currently** have **N** for **Never**

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke-which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Flower Mound Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____
Patient Name (print)

_____ ____/____/____ _____ *Office Initials*
Patient or Authorized Person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY: *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.*

☐ The first day of my last menstrual cycle was on ____/____/____

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____
Patient Name (print)

_____ ____/____/____ _____ *Office Initials*
Patient or Authorized Person's Signature Date

Flower Mound Chiropractic - NOTICE OF PRIVACY PRACTICES

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. Emergency - in the event of a medical emergency we may notify a family member.
5. For Public health and safety - to prevent or lessen a serious or eminent threat to the health or safety of a person or public.
6. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
7. For military, national security, prisoner, and government benefits purposes.
8. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
9. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or notify you of changes in practice hours or upcoming events.
10. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours), including an X-ray disc.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr Nick Ponomarenko, D.C. at (972-539-2323) If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Flower Mound Chiropractic NOTICE REGARDING YOUR RIGHT TO PRIVACY

I have received a copy of Flower Mound Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient's Name Date

_____

Patient's Signature

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Your protected health information (PHI) will be used by this office and/or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limits use of health information including your demographic information collected from you and created or received by this office. You may review the notice prior to signing this consent. You may request a copy at the front desk. This office reserves the right to modify the Privacy Practices outlines in the notice.

Restriction on the use or disclosure of your information: You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment or health care operations.

Revocation of consent: You may revoke this consent to the use and disclosure of your PHI. 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.

I _____ (**print**) acknowledge that I have reviewed the above information and **(A)** do or **(B)** do not authorize this office to release information concerning my condition and treatment to my insurance company, attorney, or insurance adjuster for the purposes of processing my claim for benefits and payment of services rendered to me. I do understand that if I choose to refuse release of this information, that my PHI will be used within the office for purposes of my care to those individuals designated by the doctor.

Flower Mound Chiropractic may speak with the following individuals or entities about PHI:

Spouse: _____

Parent/Child: _____

Employer: _____

Attorney: _____

Other: _____

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE PERSONAL INJURY, ERISA, AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

Dr Nick Ponomarenko, D.C.
Flower Mound Chiropractic
5810 Long Prairie Road, Suite 300
Flower Mound, TX 75028

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, any and all medical benefits and/or any insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of all medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_____

Patient Signature

_____

Date

MAINTENANCE POLICY

Chiropractic, massage, and various physical therapy treatments are an important part of helping you achieve optimal health. However, your ability to access these benefits as provided by your insurance company is subject to the rules, regulations, and policy language set forth in your specific insurance plan. Often times there is a misunderstanding regarding what types of treatments are "covered and deemed 'medically necessary'". It is important to note that all insurance companies have detailed policy language that indicates chiropractic, massage, and physical therapy for **MAINTENANCE** are **NOT** considered medically necessary.
Please read the following examples of corporate medical policies regarding "maintenance therapies"

BCBS Premera
When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is considered maintenance therapy. **Maintenance therapy is not a covered benefit.**
BCBS Regence, & BCBS
Chiropractic maintenance therapy is considered **not medically necessary.**
Aetna
Once a maximum therapeutic benefit has been achieved, continuing chiropractic are is not considered medically necessary and thus is not covered. **Preventative or maintenance therapy is not covered.**
Centers for Medicare Services (CMS)
MEDICARE: When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy. **Maintenance therapy is no considered medically necessary.**
Once a functional status has been remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulation **treatment is considered maintenance therapy and is not medically necessary.**
United Health Care
Once a maximum benefit has been reached, continuing chiropractic care is considered **not medically necessary.**
Chiropractic therapy is considered to be maintenance therapy is any of the following apply:

- Further clinical and functional improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment has become supportive rather than corrective in nature.
- The treatment plan seeks to prevent disease, promote health, and prolong and enhance the quality of life.
- Therapy is performed to maintain or prevent deterioration of a chronic condition, including but not limited to intermittent treatment for recurrent symptoms unrelated to a new injury.

By signing below, I acknowledge that I have been informed regarding the medical necessity of Maintenance Care and I understand that it is not a covered benefit under my insurance plan and agree to pay out-of-pocket for these services.

Patient Name:_____ Signature:_____ Date_____

PREMERA | BLUE CROSS Regence Aetna CMS CENTERS for MEDICARE & MEDICAID SERVICES UnitedHealthcare