

# Patient Information

Fort Wayne Chiropractic | Gregory J. Hough, D.C.

Patient Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Name you prefer to go by: \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

SS# \_\_\_\_\_

Gender:  M  F      Marital Status:  Married  Single  Divorced  Widowed  Partnered

Home Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Primary Number:  Home  Work  Cell      Secondary Number:  Home  Work  Cell

Please note: text and email reminders are sent with minimal personal information. These messages are sent securely with our software, but once it reaches your phone/computer it is only as safe as you and your phone/email company's security.

Text appointment reminders

Email appointment reminders      email address: \_\_\_\_\_

Your Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone Number \_\_\_\_\_ Relation \_\_\_\_\_

Whom may we thank for your referral? \_\_\_\_\_

CONDITION      Workers Compensation Related?  Yes  No      Auto Accident Related?  Yes  No

## Informed Consent

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury.

The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illness or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Fort Wayne Chiropractic I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon request.

\*Signature \_\_\_\_\_ Date \_\_\_\_\_

## My Privacy

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 these privacy practices will be followed by Fort Wayne Chiropractic to ensure the privacy of my personal health information.

\*Signature \_\_\_\_\_ Date \_\_\_\_\_

# Financial Policy

Fort Wayne Chiropractic | Gregory J. Hough, D.C.

**Insurance:** All patients are responsible for finding out their chiropractic coverage. We will be happy to submit your claims and assist you in getting your claims paid promptly. If you fail to provide our office with your correct insurance information, you will be held responsible for the balance on your account. All co-payments are due at the time services are rendered. If our office is not participating with your insurance company, you will be responsible for the complete balance your insurance requires. If you have not met your deductible, you are responsible for the full balance that insurance deems patient responsibility. It is your responsibility to ensure that the insurance referral is in place if your insurance carrier requires it. You authorize direct payment of your insurance benefits to Fort Wayne Chiropractic for chiropractic services rendered.

**Self-Pay Patients:** Our office offers a 50% time-of-service discount if services are paid for on the date of service or within 3 days of the date of service for patients with no insurance or limited coverage insurance. Should you choose to submit an insurance claim for these services on your own, our office will not appeal any claims that are denied. Should the patient or the patient's insurance company request copies of treatment notes, the patient will be required to pay for these copies.

**Returned Check:** In addition to the face value of the check, you will be billed a return check fee of \$25.00.

**Billing:** By being seen at Fort Wayne Chiropractic you accept responsibility for payment of all charges incurred, which may include a 20% interest fee after 5 months of a delinquent account, as well as all collection agency costs and/or attorney fees should such actions become necessary.

## LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS (Insured patients only)

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits either to myself or to the party below who accepts assignment.

*All patients: by signing below you agree to everything in the above financial policy.*

**\*Patient Name (print)** \_\_\_\_\_

**\*Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Is your insurance:**  Medicare  Medicaid  Through an employer  Marketplace  Other \_\_\_\_\_

## INSURANCE SUBSCRIBER INFORMATION: *If the subscriber is the patient, this section does not need to be filled out*

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to Patient \_\_\_\_\_ Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone # \_\_\_\_\_

# Failed Appointment Policy

We require that you call at least 24 hours in advance to cancel your scheduled appointment. A cancellation that is not made 24 hours in advance is considered a failed appointment. To cancel your appointment, please call Fort Wayne Chiropractic at (260) 492-8300. Do not cancel your appointment by replying to the text message or email reminders.

Appointments are scheduled every 15 minutes. If you are 15+ minutes late arriving to your scheduled appointment, this is also considered a failed appointment.

If you have 3 failed appointments during the calendar year you will incur a \$25 charge. You are responsible for any failed appointment charges that you may incur. Your insurance company does not allow this charge; therefore we will not bill your insurance.

By signing below, you understand and agree to adhere to the Fort Wayne Chiropractic Failed Appointment Policy.

**\*Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

*We encourage you to take a detailed Office Information and Policies Pamphlet that is available to at the check-in counter. This pamphlet should answer any questions you have about Fort Wayne Chiropractic and our policies.*

# PERMISSION TO SHARE LIMITED HEALTH INFORMATION

Fort Wayne Chiropractic | Gregory J. Hough, D.C.

**Patient Name (print)** \_\_\_\_\_

**Date Of Birth** \_\_\_\_\_

By signing this paper below, I give permission to the person(s) listed in the table below to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friends in order to assist with my continuing care. This permission will be considered ongoing until I state in writing otherwise.

**ALL COLUMNS MUST BE FILLED OUT FOR EACH PERSON LISTED →**

Name of individual (parents and spouses must be added if they are to have any access )	Relationship with patient	Specify Information Allowed
		<input type="checkbox"/> Appointment information <input type="checkbox"/> May check balances <input type="checkbox"/> Full access <input type="checkbox"/> Other _____
		<input type="checkbox"/> Appointment information <input type="checkbox"/> May check balances <input type="checkbox"/> Full access <input type="checkbox"/> Other _____
		<input type="checkbox"/> Appointment information <input type="checkbox"/> May check balances <input type="checkbox"/> Full access <input type="checkbox"/> Other _____
		<input type="checkbox"/> Appointment information <input type="checkbox"/> May check balances <input type="checkbox"/> Full access <input type="checkbox"/> Other _____

**Fort Wayne Chiropractic has my permission to: (Please check all that apply)**

- Leave detailed message **at home** with: NAME: \_\_\_\_\_ Relationship: \_\_\_\_\_
- Leave detailed message on my **cell phone** Cell phone number: \_\_\_\_\_
- Leave detailed message on my **home answering machine** Home phone number: \_\_\_\_\_
- Leave detailed message on my **voicemail at work** Work phone number: \_\_\_\_\_

In order to obtain information by telephone, the party calling Fort Wayne Chiropractic must be able to confirm the patient's date of birth with the staff.

\_\_\_\_\_  
\*Signature of patient or legal guardian

\_\_\_\_\_  
Date

**Patient Name:**

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## **Voluntary Advance Beneficiary Notice of Non-Coverage (ABN)**

- 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.
- Sign and date the bottom of this form.

**NOTE:** If your insurance doesn't pay for service(s) below, you may have to pay.

If your insurance does not consider these charges covered services under your benefits or if you meet your maximum number of visits for the year the services below will be the patient's responsibility. It is up to you, the patient, to check your coverage with your insurance.

If you pay for non-covered services at the time of your appointment we will give you a 50% discount. The prices below do not reflect this discount.

<b>Service Description</b>	<b>Estimated Cost</b>	<b>Reason Insurance May Not Pay:</b>
<b>E/M services (new patient or established patient examination)</b>	<b>\$160.00-60.00</b>	<b>Non-covered services per your insurance benefits.</b>  <b>Benefit maximum met for the year.</b>
<b>Manual therapy</b>	<b>\$40.00</b>	
<b>Non-spine manipulation</b>	<b>\$40.00</b>	
<b>Spinal Manipulation</b>	<b>\$40.00</b>	

### **OPTIONS:**

- OPTION 1.** I want the service(s) listed above. You may ask to be paid now, but I also want my insurance billed for an official decision on payment. I understand that if my insurance doesn't pay, I am responsible for payment, but **I can appeal to my insurance.**
- OPTION 2.** I want the service(s) listed above, but do not bill my insurance. You may ask to be paid now as I am responsible for payment. **I cannot appeal if my insurance is not billed.**
- OPTION 3.** I don't want the service(s) listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if my insurance would pay.**

**This notice gives our opinion, not an official insurance decision.**

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

<b>Signature:</b>	<b>Date:</b>
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# Pain Assessment

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Check what area of your body you want the doctor to work on, one body area per complaint box.  
The doctor will only work on areas that you mark on this pain assessment.**

Were you referred to us by another medical provider for your complaints? If yes, who? \_\_\_\_\_

## Complaint #1 (main complaint)

**Body Area:**  Head  Jaw  Neck  Upper Back  Mid Back  Low Back  Buttocks  Hip  Ribs  
 Shoulder  Upper arm  Elbow  Forearm  Hand  Wrist  Thigh  Knee  Calf  Ankle  Foot

**What side of body:**  Right  Left  Right and Left  Middle **Front or back of body:**  Front  Back

**Symptom Frequency:**  Rare (0-25% of the day)  Occasional (26-50% of the day)  Frequent (51-75% of the day)  Constant (76-100% of the day)

**Symptoms:**  Ache  Burning  Dull  Headache  Numbness  Pain  Sharp  Shooting  Spasms  Stiff  Tender  Throbbing  Tingling

**When did this occurrence of symptoms begin? If chronic, when did your symptoms get bad enough you decided to seek treatment?**  
\_\_\_\_\_

**Have you had this issue in the past?**  Yes  No

**Since your symptoms began, have they...**  Mildly improved  Improved  Mildly worsened  Worsened  Stayed the same

**Current symptom severity**  0 (none)  1 (very mild)  2 (discomfort)  3 (tolerable)  4 (distressing)  5 (very distressing)  
 6 (intense)  7 (very intense)  8 (horrible)  9 (unbearable)  10 (near unconsciousness)

**When do your symptoms occur?**  Morning  Afternoon  Evening  During the night  After work  Other \_\_\_\_\_

**What caused your symptoms?** (ex: fell down, lifted heavy box) \_\_\_\_\_

**What improves your symptoms?** (ex: lying down) \_\_\_\_\_ **What makes them worse?** \_\_\_\_\_

**Do your symptoms radiate?** (Ex: numbness in hands, pain shooting down leg)  Yes  No **If yes, to where** \_\_\_\_\_

**What medical care have you received for this latest occurrence of symptoms?** \_\_\_\_\_

## Complaint #2

**Body Area:**  Head  Jaw  Neck  Upper Back  Mid Back  Low Back  Buttocks  Hip  Ribs  
 Shoulder  Upper arm  Elbow  Forearm  Hand  Wrist  Thigh  Knee  Calf  Ankle  Foot

**What side of body:**  Right  Left  Right and Left  Middle **Front or back of body:**  Front  Back

**Symptom Frequency:**  Rare (0-25% of the day)  Occasional (26-50% of the day)  Frequent (51-75% of the day)  Constant (76-100% of the day)

**Symptoms:**  Ache  Burning  Dull  Headache  Numbness  Pain  Sharp  Shooting  Spasms  Stiff  Tender  Throbbing  Tingling

**When did this occurrence of symptoms begin? If chronic, when did your symptoms get bad enough you decided to seek treatment?**  
\_\_\_\_\_

**Have you had this issue in the past?**  Yes  No

**Since your symptoms began, have they...**  Mildly improved  Improved  Mildly worsened  Worsened  Stayed the same

**Current symptom severity**  0 (none)  1 (very mild)  2 (discomfort)  3 (tolerable)  4 (distressing)  5 (very distressing)  
 6 (intense)  7 (very intense)  8 (horrible)  9 (unbearable)  10 (near unconsciousness)

**When do your symptoms occur?**  Morning  Afternoon  Evening  During the night  After work  Other \_\_\_\_\_

**What caused your symptoms?** (ex: fell down, lifted heavy box) \_\_\_\_\_

**What improves your symptoms?** (ex: lying down) \_\_\_\_\_ **What makes them worse?** \_\_\_\_\_

**Do your symptoms radiate?** (Ex: numbness in hands, pain shooting down leg)  Yes  No **If yes, to where** \_\_\_\_\_

**What medical care have you received for this latest occurrence of symptoms?** \_\_\_\_\_

# Pain Assessment (page 2)

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Check what area of your body you want the doctor to work on, one body area per complaint box.  
The doctor will only work on areas that you mark on this pain assessment.**

## Complaint #3

**Body Area:**  Head  Jaw  Neck  Upper Back  Mid Back  Low Back  Buttocks  Hip  Ribs  
 Shoulder  Upper arm  Elbow  Forearm  Hand  Wrist  Thigh  Knee  Calf  Ankle  Foot

**What side of body:**  Right  Left  Right and Left  Middle **Front or back of body:**  Front  Back

**Symptom Frequency:**  Rare (0-25% of the day)  Occasional (26-50% of the day)  Frequent (51-75% of the day)  Constant (76-100% of the day)

**Symptoms:**  Ache  Burning  Dull  Headache  Numbness  Pain  Sharp  Shooting  Spasms  Stiff  Tender  Throbbing  Tingling

**When did this occurrence of symptoms begin? If chronic, when did your symptoms get bad enough you decided to seek treatment?**  
\_\_\_\_\_

**Have you had this issue in the past?**  Yes  No

**Since your symptoms began, have they...**  Mildly improved  Improved  Mildly worsened  Worsened  Stayed the same

**Current symptom severity**  0 (none)  1 (very mild)  2 (discomfort)  3 (tolerable)  4 (distressing)  5 (very distressing)  
 6 (intense)  7 (very intense)  8 (horrible)  9 (unbearable)  10 (near unconsciousness)

**When do your symptoms occur?**  Morning  Afternoon  Evening  During the night  After work  Other \_\_\_\_\_

**What caused your symptoms?** (ex: fell down, lifted heavy box) \_\_\_\_\_

**What improves your symptoms?** (ex: lying down) \_\_\_\_\_ **What makes them worse?** \_\_\_\_\_

**Do your symptoms radiate?** (Ex: numbness in hands, pain shooting down leg)  Yes  No **If yes, to where** \_\_\_\_\_

**What medical care have you received for this latest occurrence of symptoms?** \_\_\_\_\_

## Complaint #4

**Body Area:**  Head  Jaw  Neck  Upper Back  Mid Back  Low Back  Buttocks  Hip  Ribs  
 Shoulder  Upper arm  Elbow  Forearm  Hand  Wrist  Thigh  Knee  Calf  Ankle  Foot

**What side of body:**  Right  Left  Right and Left  Middle **Front or back of body:**  Front  Back

**Symptom Frequency:**  Rare (0-25% of the day)  Occasional (26-50% of the day)  Frequent (51-75% of the day)  Constant (76-100% of the day)

**Symptoms:**  Ache  Burning  Dull  Headache  Numbness  Pain  Sharp  Shooting  Spasms  Stiff  Tender  Throbbing  Tingling

**When did this occurrence of symptoms begin? If chronic, when did your symptoms get bad enough you decided to seek treatment?**  
\_\_\_\_\_

**Have you had this issue in the past?**  Yes  No

**Since your symptoms began, have they...**  Mildly improved  Improved  Mildly worsened  Worsened  Stayed the same

**Current symptom severity**  0 (none)  1 (very mild)  2 (discomfort)  3 (tolerable)  4 (distressing)  5 (very distressing)  
 6 (intense)  7 (very intense)  8 (horrible)  9 (unbearable)  10 (near unconsciousness)

**When do your symptoms occur?**  Morning  Afternoon  Evening  During the night  After work  Other \_\_\_\_\_

**What caused your symptoms?** (ex: fell down, lifted heavy box) \_\_\_\_\_

**What improves your symptoms?** (ex: lying down) \_\_\_\_\_ **What makes them worse?** \_\_\_\_\_

**Do your symptoms radiate?** (Ex: numbness in hands, pain shooting down leg)  Yes  No **If yes, to where** \_\_\_\_\_

**What medical care have you received for this latest occurrence of symptoms?** \_\_\_\_\_

# Activities of Daily Living

Fort Wayne Chiropractic | Gregory J. Hough, D.C.

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

**Directions:** For each body area you need the doctor to treat, please choose one activity that is the most affected by your symptoms. Example is in blue in the first row

0 = none    1 = very mild    2 = discomfort    3 = tolerable    4 = distressing    5 = very distressing  
 6 = intense    7 = very intense    8 = horrible    9 = unbearable    10 = worst pain imaginable

Fill in the ONE column that best describes your situation



<b>Activity</b>	<b>Body Area Affected</b>	<b>Length of time before symptoms begin while doing activity</b>	<b>Symptom severity on a scale of 0-10 while doing activity</b>
Walking	Lower back	10 <input checked="" type="checkbox"/> Minutes <input type="checkbox"/> Hours	5
<b>Bending</b>	_____	_____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours	_____
<b>Employment duties</b>	_____	_____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours	_____
<b>Exercise/ Working out</b>	_____	_____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours	_____
<b>Household work</b>	_____	_____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours	_____
<b>Lifting</b>	_____	_____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours	_____
<b>Lying down</b>	_____	_____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours	_____
<b>Sitting</b>	_____	_____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours	_____
<b>Standing</b>	_____	_____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours	_____
<b>Walking</b>	_____	_____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours	_____
<b>Range of motion</b>	_____	_____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours	_____
(other) _____	_____	_____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours	_____
(other) _____	_____	_____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours	_____

No activity is affected in any way by my symptoms. My goal for treatment today is: \_\_\_\_\_

\_\_\_\_\_

# Patient Health History

Fort Wayne Chiropractic | Gregory J. Hough, D.C.

Patient Name \_\_\_\_\_

Please answer every question. If the question does not apply to you, check the "None" box.

<b>Musculoskeletal</b> <input type="checkbox"/> Muscle pain <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Muscle cramps <input type="checkbox"/> Muscle spasms <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Joint pain <input type="checkbox"/> Swollen joints <input type="checkbox"/> Low back pain <input type="checkbox"/> Mid back pain <input type="checkbox"/> Upper back pain <input type="checkbox"/> Neck pain <input type="checkbox"/> Arm/Leg pain <input type="checkbox"/> Broken bones <input type="checkbox"/> Fractured bones <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Implants/plates <input type="checkbox"/> None	<b>Neurological</b> <input type="checkbox"/> Seizures <input type="checkbox"/> Vertigo <input type="checkbox"/> Dizziness <input type="checkbox"/> Incoordination <input type="checkbox"/> Weak grip <input type="checkbox"/> Paralysis <input type="checkbox"/> Difficult speech <input type="checkbox"/> Tingling <input type="checkbox"/> Loss of memory <input type="checkbox"/> Numbness <input type="checkbox"/> Tremors <input type="checkbox"/> Fainting <input type="checkbox"/> Parkinsons <input type="checkbox"/> Concussion <input type="checkbox"/> Alzheimers <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Stroke <input type="checkbox"/> None	<b>Head/ENT</b> <input type="checkbox"/> Hearing Defect/Loss <input type="checkbox"/> Headaches or migraines <input type="checkbox"/> Ringing in ear(s) <input type="checkbox"/> TMJ problems <input type="checkbox"/> None <b>Cardiovascular</b> <input type="checkbox"/> Chest pain/discomfort <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> None
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Have you had any imaging scans in the past that are relevant to today's treatment?

None

Date \_\_\_\_\_ Body area \_\_\_\_\_ Results \_\_\_\_\_  X-ray  MRI  CT  
Date \_\_\_\_\_ Body area \_\_\_\_\_ Results \_\_\_\_\_  X-ray  MRI  CT  
Date \_\_\_\_\_ Body area \_\_\_\_\_ Results \_\_\_\_\_  X-ray  MRI  CT

Have you had any hospitalizations or surgeries in the past that are relevant to today's treatment?

None

Date \_\_\_\_\_ Reason/Type of surgery \_\_\_\_\_  Surgery  Hospitalization  
Date \_\_\_\_\_ Reason/Type of surgery \_\_\_\_\_  Surgery  Hospitalization  
Date \_\_\_\_\_ Reason/Type of surgery \_\_\_\_\_  Surgery  Hospitalization

Have you had any injuries in the past, other than those listed above, that are relevant to today's

treatment?  None \_\_\_\_\_

Relevant Family History (ex: father-arthritis):  None \_\_\_\_\_

Lifestyle Habits: work \_\_\_\_\_ hours/week --  light labor  moderate labor  heavy labor  repetitive  
 computer  mostly sitting  mostly standing  mostly walking  difficult  stressful

Exercise Habits:  Weekly  Daily  None

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_