Application for Chronic Knee Pain Treatment

Name:__________________________________ **Date:**_____________________

Address:____

City:__________________ State:_____ Zip:_____________Home Phone:_________________________

Cell Phone:____________________ Email:____

Social Security #:______-_____-_______ Date of Birth: _____/_____/______ Age:______

Spouse's Name:____

Your Occupation (Current or Previous):____Retired? Y N

Insurance Provider:_________________________ Member ID:__________________________________

Whom may we thank for referring you to us? ____

Review of Systems

Please check all that apply:

☐ Knee Pain L / R	☐ Arthritis in knee	☐ Bulging Discs	☐ Morton's Neuroma	☐ Diabetes
☐ Leg Pain	☐ Arthritis in Feet	☐ Degenerative Discs	☐ Poor Circulation	☐ Cancer
☐ Foot Pain	☐ Foot Surgery	☐ Joint Replacements	☐ High Blood Pressure	☐ Chemotherapy
☐ Low Back Pain	☐ Spinal Stenosis	☐ Plantar Fasciitis	☐ High Cholesterol	
☐ Sciatica	☐ Restless Leg Syndrome	☐ Implanted Cord/ Bladder Stimulator	☐ Pacemaker	

Present Health Condition

In order of importance, list the health problems you are most interested in getting corrected:

1)____

2)____

3)____

Approximately how long you have noticed these problems?

____

____

____

____

Check the things you have used for these problems:

☐ Gabapentin	☐ Lyrica	☐ Cymbalta
☐ Ibuprofen	☐ Aleve	☐ Injections
☐ Physical Therapy	☐ Massage	☐ Chiropractic
☐ Yoga	☐ Supplements	☐ Acupuncture

Have your symptoms:

☐ Improved ________________________

☐ Worsened ________________________

☐ Stayed the same ________________________

How would you describe the symptoms? Please check all that apply:

□ Aching Pain	□ Numbness	□ Hot sensation	□ Cramping
□ Stabbing Pain	□ Tingling	□ Throbbing Pain	□ Swelling
□ Sharp Pain	□ Pins and Needles Pain	□ Dead Feeling	□ Burning
□ Tiredness	□ Clicking/Popping	□ Cold Feet	□ Electric Shocks

Does this condition interfere with any of the following?

□ Sleep □ Work □ Daily Activities □ Exercise □ Recreational Activities □ Walking □ Standing □ Squatting

Do you exercise regularly? □Yes □No If yes, describe what type and how often:______________________________

Do you smoke? □ Yes □ No If yes, how many packs/daily: ________

Do you drink? □ Yes □ No If yes, how many drinks/week:________

How would you rate your pain in the last week?

No Discomfort Worst Discomfort Possible

0 1 2 3 4 5 6 7 8 9 10

If you had to accept some level of pain after completion of treatment, what would be an acceptable level?

No Discomfort Worst Discomfort Possible

0 1 2 3 4 5 6 7 8 9 10

Knee Pain Questionnaire

How often is your knee painful?	☐ Never	☐ Monthly	☐ Weekly	☐ Daily	☐ Always
Describe the degree of pain when extending knee fully.	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Describe the degree of pain when bending knee fully.	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Describe the degree of pain when going up/down stairs.	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Do you have swelling in your knee?	☐ Never	☐ Rarely	☐ Sometime	☐ Often	☐ Always
Do you feel grinding in your knee?	☐ Never	☐ Rarely	☐ Sometime	☐ Often	☐ Always
Do you hear clicking/pops/other noise when knee moves?	☐ Never	☐ Rarely	☐ Sometime	☐ Often	☐ Always
Does your knee catch or hang up when moving?	☐ Never	☐ Rarely	☐ Sometime	☐ Often	☐ Always
What degree of difficulty do you have getting in/out of car?	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
What degree of difficulty do you have putting on socks?	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
What degree of difficulty do you have taking off socks?	☐ Never	☐ Monthly	☐ Weekly	☐ Daily	☐ Always
What degree of difficulty do you have squatting?	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
What degree of difficulty do you have when running?	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
What degree of difficulty do you have jumping?	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
What degree of difficulty do you have twisting/turning?	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
In general, how much difficulty do you have with your knee?	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme

Previous Health History

Please give name, address, and office phone of your primary care physician/family doctor:

Name: ____

When were you last seen? :______________________________

List ALL Allergies (or Sensitivities) to Medicines, Foods, and other items:

Item you react to:	Reaction:

Please list the prescription drugs you are currently taking, or <u>attach list</u>:

Name:	**Dose (MG or IU)**	**Purpose**

List all Nutritional Supplements (vitamins, herbs, homeopathic, etc.) as above:

This is a confidential record of your medical history and pertinent personal information. The doctor reserves the right to discuss this information with medical and allied health professionals per the informed consent. By providing the signature below, I certify that the information provided is accurate and true.

Name:________________________________ **Signature:** ________________________________**Date:**______

Welcome to Prax Chiropractic And Massage: A Functional Neurology Center!

Notice of Privacy Practices
HIPAA (Health Insurance Portability and Accountability Act)
Protecting Your Confidential Health Information is Important to Us!

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It was updated 9/23/13 in accordance with HIPAA Policy. Please review it carefully.

Dear Patient:

This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA – Health Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office. The term **PHI** means **protected health information**.

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in health care. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws; we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

The 9/23/2013 HIPAA update to this notice includes changes related to disclosures to health plans, marketing, copies of ePHI, breach notification, and the sale of your PHI further described below.

How your HEALTH INFORMATION may be used

To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between physician assistant, nurse, physician and business office staff. In addition, we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment option or services that may be of interest to you or your family.

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or to national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care. In the event of death, we are may also may share information with your family, caregivers, or those involved with payment for care unless there is a written request from you not to do so.

To Coroners, Funeral Directors and Medical Examiners

We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral.

Medical Research

Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval and of an Institutional Review Board. Physicians may combine conditioned and unconditioned authorizations if the individual can opt-in to the unconditioned research activity. These authorizations may encompass future research.

Marketing and Fundraising

We are limited in providing third party marketing communications about a product or service to you without a separate written authorization unless we receive no compensation, the communication is face to face, the communication is a drug or biologic you are currently being prescribed and the payment is limited to reasonable reimbursement of the costs of communication, the communication is a general not specific health or product promotion, or the communication involves government–sponsored programs. If we do any fundraising you may opt out of communications about this.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Notification of Breach of Security

We are required by law to maintain the privacy of your health information and we are required to report to you if there is a breach of security unless, after completing a risk analysis, it is determined there is a "low probability of PHI compromise." We will use the four factors of risk assessment as outlined by the new privacy rules.

Patient Rights

This law is careful to describe that you have certain rights. This includes the right to be informed of and control your protected health information (PHI) including the right to inspect, amend, and obtain an electronic copy of your PHI, the right to receive confidential communications by "alternative means or at alternative locations, the right to restrictions on disclosures to health plans for treatments paid in full by the patient, the right to have a designated record sent to a third party, the right to prohibit the sale of your PHI, its use for marketing purposes, or participation in research, the right to a disclosure to third parties given access to your PHI, and the right to complain about a HIPAA violation.

Restrictions, Disclosures to Health Plans, Sale of PHI

You have the right to request certain uses and disclosures of your health information. At your request, we may not disclose information about care you have paid for out-of-pocket to health plans unless for treatment purposes or if the disclosure is required by law. The sale of your personal health information is prohibited unless we have a separate written permission and extends to licenses, lease agreements, and to the receipt of financial or in kind benefit. It also includes disclosures in conjunction with research if there is any profit margin.

Confidential Communications, e-PHI, Emailing PHI

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present. We must respond to your written requests for your ePHI within 30 days with a one 30 day extension in a mutually agreed electronic form or format if the records are readily reproducible in that format. Hardcopies are only permitted when you reject all readily reproducible e-formats. We may use unencrypted email for your PHI only if you request that form of transmission and know that there could be a transmission security risk.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. There may be a reasonable charge to a paper copy and assemble your records, or if electronic, the purchase of portable media such as a cd or memory stick.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change. Your request may be denied if the health information record in question was not created by our office, is not a part of our records or if the records containing your health information are determined to not be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

Patient Acknowledgment

Patient Name(s):____

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Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledging you r receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

____

Patient Signature Date

Chiropractic Terms of Acceptance

When we accept you as a patient into our practice, it is important that you understand the objectives of our care.

Chiropractors provide a unique service that other healthcare providers do not offer: the location and correction of vertebral subluxations (spinal nerve stress) in your body.

A vertebral subluxation is a misalignment or distortion of your spinal column or related structures that can affect your brain, nervous system and overall body function. Subluxations can cause disease or loss of proper body function.

Chiropractors spend years studying how to locate and correct this destructive condition, first by analyzing your body structure (especially your spine) using various methods. Second, we correct or adjust your subluxations by using specialized technique (spinal adjustment). When your spine and nervous system are free from the deep stress of vertebral subluxations you function more efficiently and your natural healing ability, your inner healer, will better communicate through your body.

We do not medically diagnose or treat any disease, symptom or condition. No matter what condition(s) you may have been diagnosed with and no matter what symptom(s) your body is expressing, you always need a body free from subluxations.

If, during the course of our chiropractic spinal examination, we encounter unusual findings, we will let you know of them. You may then decide whether you wish to investigate further and discuss your healthcare options with other healthcare professionals. We will cooperate with you and with them in your goals.

To summarize: the purpose of chiropractic care is not to treat diseases or conditions, nor to suppress symptoms, nor to perform surgery, but rather to make your body function better by removing spinal nerve stress (subluxations). Therefore we do not prescribe surgery or medications. If you wish to decrease or stop medications you should discuss that with your MD.

Our objective is to eliminate a major interference to the expression of your physical/emotion health and healing vertebral subluxations so that your natural healing ability and your inner healer may function without this severe form of stress.

By signing below, you are confirming that you have had the opportunity to read and understand the “Chiropractic Terms of Acceptance”.

____

Signature Date

A. Notifier: **Prax Chiropractic, 300 Hickman Rd, Suite 301 Charlottesville, VA 22911**

B. Patient Name ________________________ **C. Identification Number:** ________________

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** ____________ 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.	E. Reason Medicare May Not Pay:	F. Estimated Cost
1) Patient Evaluations or Exams 2) Scans 3) Massage 4) Manual Therapy 5) Extraspinal Adjustment 6) Maintenance Adjustments 7) O2 and Vibration Therapy 8) Brain Based Therapies	Medicare **only** pays for Spinal Adjustments/Spinal Manipulations that are medically necessary.	1) $45-100 2) $50 3) $25 per 15 min 4) $30 per 15 min 5) $25 6) $45-55 7) $25 per 15 min 8) $30 per 15 min

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

CASH ADVANCE BENEFITS NOTICE

Patient's Name:		DOB		SSN	
Address	,	State		Zip	

Additional Notes:

General Services	**Description**	**Doctor or Therapist Charge for Services***
Spinal Adjustments	Manipulation of any of the five spinal areas: Cervical, Thoracic, Lumbar, Sacral and Pelvic regions.	$45 to $55
Non Spinal/Extremity Adjustment	Other areas of adjustment including Head, Face,TMJ, Upper Extremity (Shoulder, Upper Arm, Elbow, Lower Arm, Wrist, Hand, Finger), Lower Extremities (Thigh,Knee, Lower Leg, Ankle, Foot, Toe), Ribs and Abdomen.	$25
Manual Therapy	Can include Trigger Point Therapy, Manual Traction, Myofascial Release, Manipulation/Mobilization per 15 mins.	$30
Massage Therapy	Methodical Pressure, Friction, Kneading of the body per 15 min.	$25
Patient Evaluations	Can include patient history, testing, evaluations, consultations for new or continuing patients.	$25 to $150
Surface EMG Exam	Electromyography measures muscle contraction to help determine treatment	$50
Modalities	Vibration, Heat, UBE, Therapeutic Exercises, Neuromuscular Re-Education, Warm or Cold Ear Calorics	$10 to $90
Additional Services	See Front Desk	See Front Desk

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will immediately be due and payable. I authorize the release of any medical or other information necessary to process my insurance claim if needed. I also understand I am responsible for any non-covered services from my insurance carrier when applicable. This is to serve as a long-term authorization card. I authorize payment of medical benefits to ***Prax Chiropractic*** if applicable for the services described on the insurance form that may be filed. This authorization is to apply to all occasions of service until it is revoked in writing.

I have read this agreement and agree to abide by it in full.