Bouma Chiropractic Clinic P.C. * 102 Christy Park Drive * Indiana, Pa * 15701
(724) 465-4080

File #:_____

PATIENT REGISTRATION FORM

NAME			HOME #
ADDRESS			CELL/WORK #
CITY/STATE/ZIP			E-MAIL
EMERGENCY CONTACT & PHONE			SOC SEC #
O MALE O FEMALE	O Single O Divorced O Married O Widowed	DATE OF BIRTH	SPOUSE NAME
EMPLOYER		OCCUPATION	NAMES & AGES OF CHILDREN
REFERRED BY		PRIVATE PHYSICIAN	

PREFERRED METHOD OF CONTACT (please circle one or both): TEXT _____ EMAIL
cellular provider

**You may receive an automatic text and/or email appointment reminder. Please notify the staff if you do not want to receive this.

PLEASE INDICATE REGION OF COMPLAINT

O HEADACHES O NECK PAIN
O UPPER BACK O MID BACK O LOW BACK
O SHOULDER O ELBOW O WRIST O HAND
O HIP O KNEE O ANKLE O FOOT PAIN
O OTHER *explain:*

PLEASE DESCRIBE YOUR SYMPTOMS INCLUDING ONSET DATE

_____

_____

PLEASE RATE YOUR PAIN: 0 1 2 3 4 5 6 7 8 9 10
No Pain Severe Pain

PLEASE DESCRIBE YOUR PAIN:
O Sharp O Dull O Shooting O Burning O Throbbing O Numb O Tingling

HOW LONG DOES PAIN PERSIST? _____

IT IS: O CONSTANT *76-100%* O FREQUENT *51-75%* O OCCASIONAL *26-50%* O INTERMITTENT *0-25%*

DOES PAIN SPREAD TO OTHER AREAS? IF SO, WHERE? _____

DO YOU HAVE ANY NUMBNESS OR TINGLING IN YOUR BODY? WHERE? _____

DOES ANYTHING AGGRAVATE THE COMPLAINT? _____

DOES ANYTHING MAKE THE COMPLAINT BETTER? _____

SPECIFIC INJURY?	O YES O NO	PRIOR TREATMENT?	O YES O NO
HAD TREATMENT?	O YES O NO	TX TYPE:	O Drugs O Nv Block O Phys Therapy O Surgery O Xray O MRI O EMG

MEDICAL HISTORY	YES	NO	*LIST MEDICATIONS*	
DIABETES	O	O		
STROKE	O	O	1.	4.
CANCER	O	O	2.	5.
SMOKE/TOBACCO PRODUCTS	O	O	3.	6.
DEPRESSION / ANXIETY	O	O	*LIST ALLERGIES*	
VASCULAR PROBLEMS	O	O	1.	3.
LUNG PROBLEMS	O	O	2.	4.
STOMACH PROBLEMS	O	O	5.	6.
USUAL CHILDHOOD DISEASES	O	O	*LIST SURGERIES/HOSPITALIZATIONS*	
EXERCISE REGULARLY	O	O	1.	
HIGH BLOOD PRESSURE	O	O	2.	
ALCOHOL	O	O	3.	
ALLERGIES/ASTHMA	O	O	4.	
BIRTH CONTROL MEDICATION	O	O	5.	

Dr. Initials: _____ Date: _____
LR

Name: _____
File #:_____

RELATED HEALTH QUESTIONS	YES	NO	*COMMENTS*
DOES BRIGHT LIGHT BOTHER YOU?	O	O	*LIST VITAMINS/SUPPLEMENTS:*
DO YOU HAVE COLD HANDS & FEET?	O	O	1. 2.
DO YOU GRIND YOUR TEETH?	O	O	3. 3.
DO YOU CRY EASILY?	O	O	4. 5.
DO YOU EXPERIENCE FACIAL/BODY ACNE?	O	O	6. 7.
HEIGHT:	*QUESTIONS/CONCERNS:*		
WEIGHT:			

FEMALES

BEGINNING DATE OF LAST MENSTRUAL CYCLE:	DATE:	
PREGNANCIES PLEASE LIST DATES OF DELIVERY & OUTCOME OF PREGNANCY:	DATE:	OUTCOME:
	DATE:	OUTCOME:
	DATE:	OUTCOME:
	DATE:	OUTCOME:
	DATE:	OUTCOME:

FAMILY HEALTH HISTORY

HEALTH PROBLEMS OF RELATIVES	RELATIVE:	HEALTH PROBLEM:	
	RELATIVE:	HEALTH PROBLEM:	
	RELATIVE:	HEALTH PROBLEM:	
DEATHS IN IMMEDIATE FAMILY	RELATIVE:	CAUSE:	AGE AT DEATH:
	RELATIVE:	CAUSE:	AGE AT DEATH:
	RELATIVE:	CAUSE:	AGE AT DEATH:

SOCIAL AND OCCUPATIONA HISTORY:

LEVEL OF EDUCATION: O HIGH SCHOOL O SOME COLLEGE O COLLEGE GRADUATE O POST GRADUATE STUDIES

JOB DESCRIPTION: _____

WORK SCHEDULE: _____

RECREATIONAL ACTIVITIES: _____

LIFESTYLE (hobbies, level of exercise, alcohol, tobacco and drug use, diet): _____

_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION / FINANCIAL AGREEMENT / MINOR CONSENT

I certify that I (or my dependent) assign directly to BOUMA . Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered.

I hereby authorize this office to release any information requested by my insurance company to document my claim for benefits. I understand that I am personally responsible for full payment of all charges for my treatment. Services are payable at the time rendered. X-rays remain the property of this clinic and will only be released to another physician after receiving a proper release authorization request from said physician. X-ray will not be released directly to patients.

I understand and agree that the doctors of BOUMA Chiropractic have the right to decline or accept me as a patient at any time before treatment begins. Taking a history and conducting an examination are a part of the process of information gathering, so that the doctor can determine whether to admit me as a patient or not.

I am authorized to and do consent to all treatments performed by the doctors and staff of BOUMA . Chiropractic and rendered to the minor patient named on this registration form.

_____ _____

PATIENT OR GUARDIAN SIGNATURE DATE

Dr. Initials: _____ Date:_____
LB

BOUMA CHIROPRACTIC CLINIC, P.C.

FINANCIAL POLICY

Thank you for choosing Bouma Chiropractic Clinic as your wellness care provider. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment.

INSURANCE

Your insurance policy is a contract between you and your insurance carrier. We will submit the services to your insurance carrier if you have given us all the required information. We must have correct policy, group, member ID, and claim numbers, along with a correct billing address. Please be aware that some and/or all services provided may be "non-covered" services according to your policy. If you have questions regarding the benefits on your insurance plan, you should contact your insurance company with your questions. Payment for known non-covered services is due at the time of each service, as well as co-pays, co-insurances, and deductibles. An itemized statement of your transactions is available upon request. A receipt for each daily service is made available to you at your appointment.

We accept the following insurances: Highmark, Blue Cross Blue Shield, Medicare, Aetna, and UPMC plans. We do not accept Gateway, Humana, United, Tricare, or Medicaid (Access). As a courtesy, we will bill your insurance carrier for all services upon request, or you will be responsible for our associated cash fees. Please remember that your insurance is a contract between you and your carrier, and that they will process your visits to reflect the amount you owe for the services you receive. Services you receive will be based upon your diagnosis and recommended treatment plan of care.

For auto accident or worker's compensation cases, we appreciate your cooperation with completing all necessary forms that your insurance carrier requests of you, so that your bills will be paid.

BILLING

Our office regularly sends out bills requesting payment for which the patient is responsible for. For patients utilizing insurance, processing of visits may take 30 days to several months to process your claims.

If you have a financial problem, please ask for the Office Manager to discuss your situation. Payment plans can be made and our office also participates in the care credit program which can enable you to pay off your bills in a more realistic manner. If a payment plan is offered to you, we require that you make monthly payments. Failure to comply with an arranged payment plan may cause further action to be taken. In addition, bills sent out to patients that are not satisfied in a timely manner, may be subject to being sent to a collection agency. Should this happen, you may not be able to receive treatment without payment and you will be asked to find another provider.

Please read and sign: _____ Date: _____

Our Goal

When a patient seeks chiropractic care, and when a chiropractor accepts a patient for such care, it is essential that they both be working toward the same goal. Chiropractic has only one goal, and it is important that you understand the goal and the means by which it will be attained. This way, there will be no confusion, misunderstanding or disappointment. We understand patients usually want to eliminate the condition that is bothering them as quickly as possible. This however is NOT the goal of our office.

The purpose of Chiropractic is to restore and maintain the mechanical integrity of the spinal cord and its nerve roots. These vital nerve pathways are protected by the bones of the spine. Tiny misalignments of the vertebrae (or bones of the spine) which interfere with the function of these nerve pathways are called subluxations. They come from many causes and prevent various organs from working properly.

By means of a chiropractic adjustment, subluxations are corrected, thus restoring normal nerve function. The goal of Chiropractic is to correct vertebral subluxations for the purpose of restoring proper transmission of nerve energy over the nerve pathways so that every part of the body may have a proper nerve supply at all times. This allows the innate healing ability of the body to work at maximum efficiency.

With proper nerve supply, health improves. Often symptoms clear up sometimes quickly sometimes slowly, sometimes only partially, or not at all. Regardless of what disease or symptom you may or may not have, we do not offer to cure it, treat it, or offer advice regarding it. Our only goal is to allow the body to better express its own innate health potential. The only method used is the correction of vertebral subluxations.

I, _____, have read the above and I undertake chiropractic care on this basis.

Name: _____ Date: _____

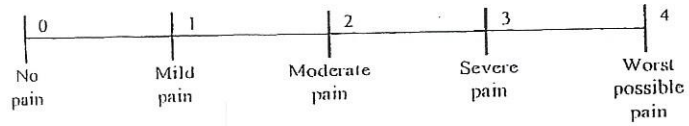
Bouma Chiropractic Clinic, P.C.
102 Christy Park Drive, Indiana PA 15701 Phone: (724)465-4080 Fax: (724)465-6923

Functional Rating Index

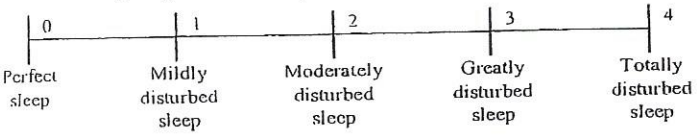
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

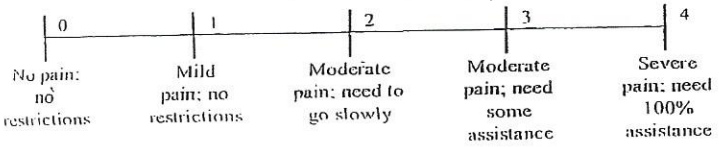
1. Pain Intensity



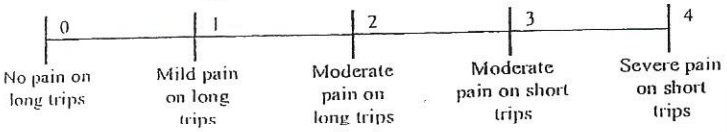
2. Sleeping



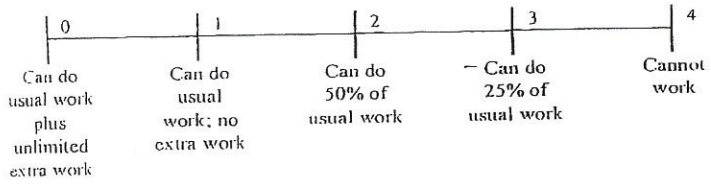
3. Personal Care (washing, dressing, etc.)



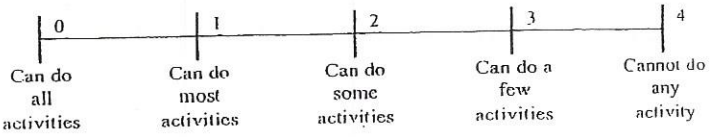
4. Travelling (driving, etc.)



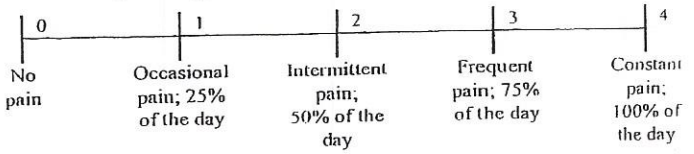
5. Work



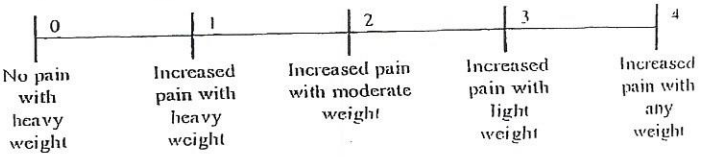
6. Recreation



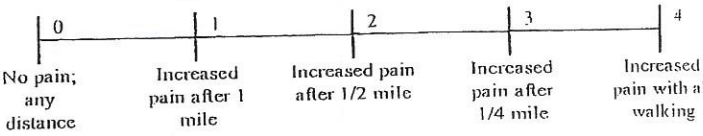
7. Frequency of Pain



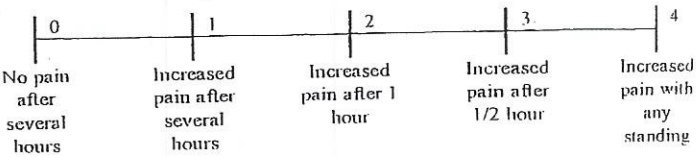
8. Lifting



9. Walking



10. Standing



_____

Patient's Signature

_____

Date

For Office Use Only:

Practitioner ID#: _____

Total Score _____ / 40

Clinical Diagnosis Codes:

Patient ID#: _____

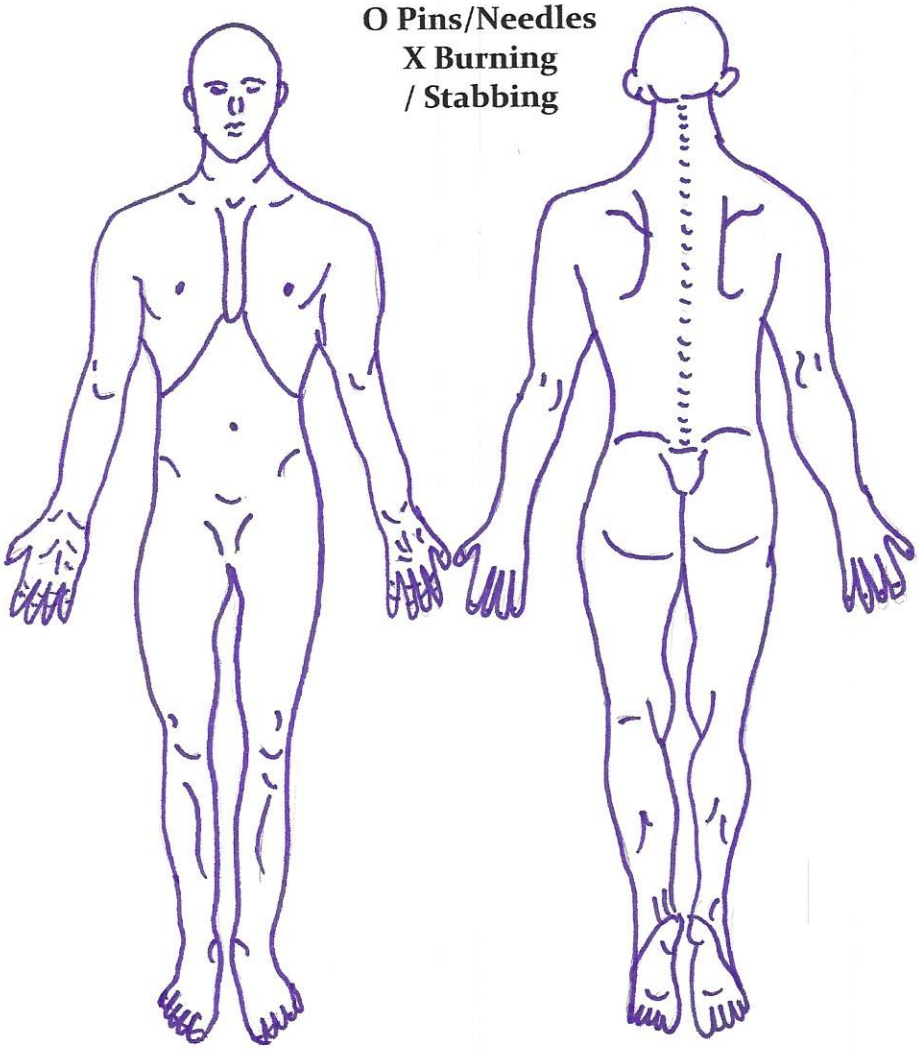
Patient Name: _____ Number: _____ Date: _____

Mark the area of your body where you have symptoms.
Use the following symbols:

- **Numbness**

O Pins/Needles
X Burning
/ Stabbing

Right Side



Right Side

Put a circle around the areas that hurt now
Use the following scales to grade the intensity of your pain

Circle the # to indicate your pain level When the problem **began**

0 1 2 3 4 5 6 7 8 9 10

Mild moderate severe

Circle the # to indicate your pain **now**

0 1 2 3 4 5 6 7 8 9 10

mild moderate severe

Permission for Disclosure

HIPPA (Health Insurance Portability and Accountability Act) has privacy rules that give you the right to approve or deny disclosure of your personal health information contained in your file. You, the patient, must give written consent to this office before we can contact you for personal reasons. However, we can contact you at any time regarding your appointment, treatment, or for billing purposes.

Check the following ways you would like to be contacted:

□ Home Phone / Work Phone (_____)_____ / (_____)_____

□ You have permission to leave a message that will contain detailed information about me at the above number.

Initials: _____

□ Cell Phone (_____)_____

□ You have permission to leave a message that will contain detailed information about me at the above number.

Initials: _____

□ Email _____

Initials: _____

□ Home Address (patient address already on file)

Initials: _____

Check one of the following two options:

□ I give Bouma Chiropractic Clinic, P.C. permission to use my name when referring patients and permission to use my testimonial for the purpose of sharing my chiropractic story with others. This form shall be valid for 7 years.

□ I do not give Bouma Chiropractic Clinic, P.C. permission to use my name when referring patients and permission to use my testimonial for the purpose of sharing my chiropractic story with others. This form shall be valid for 7 years.

Name (Print): _____

Signature: _____

Date: _____

If there is any other person that you give authorization to release any medical information, records, or any other information about your care; please list their names and information.

Name	**Phone #**	**Birth Date**	**Relationship to You**

OFFICE USE ONLY

CA: _____ Date: _____

BOUMA CHIROPRACTIC CLINIC, P.C.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS DOCUMENT CAREFULLY.

Uses and Disclosures

There are a number of situations where we may use or disclose to other persons or entities your confidential medical information. Certain uses and disclosures will require you to sign an Acknowledgement that you received our Notice of Privacy Practices, including treatment, payment and health care operations. Any use or disclosure of your protected health information requires you to sign an Authorization for anything other than treatment, payment or health care operations. Certain disclosures required by law or under emergency circumstances may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

Use and Disclosure without Patient Acknowledgement of this Notice

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes:

Treatment: We will use your medical information to make decisions about the provision, coordination or management of your health care, including diagnosing your condition ad determining the appropriate treatment for that condition. It may also be necessary to share your medical information with another health care provider whom we need to consult with respect to your care. We may also disclose certain information to a pharmacist for the purpose of filling a prescription for you, to a physical therapist to provide physical therapy under appropriate circumstances, or to a facility or other providers should you require surgery or other hospital care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to disclose information in your medical record to obtain reimbursement from you or your health insurance plan, or another insurer for our services rendered to you. This may also include determinations of eligibility or coverage under the appropriate health plan, treatment plans, pre-certification and pre-authorization of services or review of services for purposes of reimbursement. This information may also be used for billing, claims management and collection purposes together with related health care data processing through our system.

Operations: Your medical records may be used in our business planning and development operations, including improvement in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, medical review activities, and arranging for legal and auditing functions.

Use and Disclosure Without Acknowledgement or Authorization

There are certain circumstances under which we may use or disclose your medical information without obtaining your Acknowledgement or Authorization. Those circumstances generally involve public health and oversight activities, law enforcement activities, judicial and administrative proceedings and in the event of death, Specifically, we are required to report to

certain agencies information concerning certain communicable diseases, sexually transmitted diseases and HIV?AIDS status. We are also required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law enforcement officials information that you or another person are in immediate threat of danger to your health or safety as a result of violent activity. We must also provide medical record information when ordered by a court of law to do so.

Authorization for Use or Disclosure

Except as outlined in the above sections, your medical information will not be used or disclosed to any other person or entity without specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain confidentiality of the information, information will not be further disclosed to any person or entity with respect to information concerning mental health treatment, drug and alcohol abuse, HIV/AIDS, or sexually transmitted diseases which may be contained in your in you medical records. We likewise will not disclose your medical record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

Additional Uses and Disclosures

We may contact you from time to time to provide appointment reminders about treatment or other health-related benefits that may interest you.

Individual Rights

You have certain right with respect to your medical record information, as follows:

1. You may request that we restrict the uses and disclosures of your medical records information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with respect to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

2. You have the right to request receipt of confidential communications of your medical information by an alternative location. If you require such an accommodation, you will be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

3. You have the right to inspect, copy and request an amendment to your medical records. Access to your medical records will to include psychotherapy notes contained in them, or information complied in anticipation of or for use in a civil, criminal or administrative actions or proceeding or for which your access is otherwise restricted by law. We will charge a reason able fee for providing a copy of your medical records, or a summary of those records, at your request, which includes the cost of copying, postage, or preparation of an explanation or summary of the information.

4. All requests for inspection, copying and/or amending information in your medical records must be made in writing and be addressed to "Privacy Officer" at our address. We will respond to your request in a timely fashion.

5. You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your medical records information except for disclosures required for treatment, payment and health care operations, disclosures that require an Authorization, disclosures incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any 12-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same 12-month period.

6. You have the right to obtain a paper copy of this notice if the notice was initially proved to you electronically and to take one home with you if you wish.

7. All requests related to your rights herein must be make in writing and addressed to "Privacy Officer" at 102 Christy Park Drive, Indiana, PA 15701.

OUR DUTIES

We have the following duties with respect to the maintenance, use and disclosure of your medical records:

1. We are required by law to maintain the privacy of the protected health information in your medical records and to provide you with this Notice of legal duties and privacy practices with respect to that information.

2. We are required to abide by the terms of this Notice currently in effect.

3. We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and medical records we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

COMPLAINTS

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe your privacy rights with respect to confidential information in your medical records has been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of a complaint to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints on –line at the government's website: htt://www.hhs.gov/ocr/hipaa.

CONTACT PERSON

All questions concerning this Notice or requests made pursuant to it should be addressed to:

Privacy Officer
Bouma Chiropractic Clinic
102 Christy Park Drive
Indiana, PA 15701
724-465-4080
Effective Date: This notice is effective April 14, 2003 and applies to all protected health information contained in your medical records maintained by us.