INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. PLEASE PRINT

NAME______________________________ HOME #_________________ WORK# _______________ CELL#_________________

ADDRESS____ CITY__________________ STATE___________ ZIP__________

AGE_______ BIRTHDATE ______________ MARITAL STATUS: S M W D NO. OF CHILDREN_______

EMAIL ADDRESS____

PATIENT'S INFORMATION

EMPLOYER___________________________________ OCCUPATION________________________ YEARS ON JOB______

EMPLOYER ADDRESS __________________________________ CITY_______________ STATE _______ ZIP___________

INSURANCE COMPANY___________________ SS # ____________________DO YOU HAVE MEDICARE? YES ___ NO___

PRIMARY CARE PHYSICIAN ____

SPOUSE'S/PARENT'S INFORMATION
(PLEASE FILL THIS SECTION OUT IF YOU ARE NOT THE PRIMARY CARD *HOLDER)*

NAME OF SPOUSE/PARENT____________________________________ BIRTHDATE__________ SS#____________________

SPOUSE'S EMPLOYER_________________________________ OCCUPATION__________________ YEARS ON JOB_____

EMPLOYER ADDRESS_________________________________ CITY__________________ STATE_______ ZIP___________

DOES YOUR SPOUSE HAVE HEALTH INSURANCE AT WORK? YES______ NO______

REFERRED TO OUR OFFICE BY:_____________________________

HOW PAYMENT WILL BE MADE:

CASH ______ CHECK ______ CREDIT CARD ______
WORKER'S COMP.______ AUTO INS. POLICY ______ HEALTH INSURANCE ______

IS YOUR CONDITION DUE TO AN ACCIDENT? YES_____ NO______ DATE OF ACCIDENT___________________
TYPE OF ACCIDENT? AUTO_____ WORK/ON JOB_____ AT HOME_____ OTHER________________________
HAVE YOU EVER BEEN IN AN AUTO ACCIDENT? PAST YEAR___ PAST 5 YEARS ___ OVER 5 YEARS___ NEVER___

I (WE) AGREE TO PAY FOR SERVICES RENDERED TO ABOVE MENTIONED PATIENT AS THE CHARGE IS INCURRED. I UNDERSTAND AND AGREE THAT HEALTH & ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT OF ANY AND ALL SERVICES COVERED OR NOT COVERED. I ALSO UNDERSTAND IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEE FOR PROFESSIONAL SERVICES RENDERED TO ME WILL BE IMMEDIATELY DUE AND PAYABLE.

PATIENT'S SIGNATURE____ DATE ______________________________

OR GUARDIAN SIGNATURE____ DATE ______________________________

NOTICE TO OUR NEW PATIENTS: FULL PAYMENT FOR SERVICES RENDERED IS DUE AT THE END OF EACH VISIT. IF FOR ANY REASON THIS REQUEST CANNOT BE MET, ARRANGEMENTS SHOULD BE MADE IN ADVANCE BEFORE SEEING THE DOCTOR.
INSURANCE CASES: ON ALL INSURANCE ASSIGNMENTS THE DEDUCTIBLE MUST BE MET.

FULL BODY STUDY QUESTIONNAIRE

COMPLETE THESE DIAGRAMS

IF YOU ARE IN PAIN, PLEASE MARK THE EXACT LOCATION OF YOUR PAIN ON THE DIAGRAM. ALSO DESCRIBE THE TYPE AND FREQUENCY OF YOUR PAIN, AS WELL AS ANY ACTIVITY WHICH BRINGS ON OR AGGRAVATES THE PAIN. FOR EXAMPLE, DULL, SHARP, CONSISTENT, OFF & ON, WHEN STANDING, WHEN SITTING, ETC.

MAJOR COMPLAINTS

(PLEASE LIST ANY CONDITION YOU ARE BEING TREATED FOR OR ARE EXPERIENCING.)

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____

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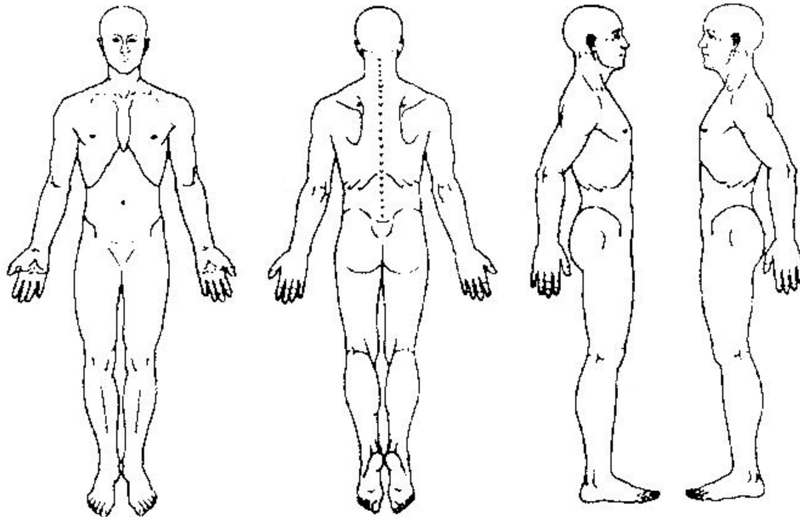
PLEASE SHOW AREAS OF:

MAIN PAIN	*	NUMBNESS	///////
SECONDARY PAIN	O	PINS AND NEEDLES	:::::::
SKIN LESIONS / SCARRING	»»		



DO YOU KNOW WHAT TRIGGERED THE PAIN ? **YES or NO** **IF YES EXPLAIN**____________________

DOES ANYTHING RELIEVE IT ? **YES or NO** **IF YES EXPLAIN**____________________

DOES ANYTHING AGGRAVATE IT ? **YES or NO** **IF YES EXPLAIN**____________________

HAS IT CHANGED SINCE IT BEGAN ? **YES or NO** **IF YES EXPLAIN**____________________

HAVE YOU HAD ANY TREATMENT ? **YES or NO** **IF YES EXPLAIN**____________________

HISTORY: INJURIES / FRACTURES / SURGERY

Consent for Chiropractic Treatment & Acknowledgment of Receipt of Information

To the patient: Every type of health care is associated with some risk of potential problem. Health care providers, including chiropractors, are required, by law, to tell you the nature of your condition, the general nature of treatment, the risks involved, and the reasonable therapeutic alternatives.

In keeping with the Louisiana law of informed consent, you are being asked to sign a confirmation that we have discussed all these matters. We have already discussed with you the common problems and risks. Please read carefully. Ask about anything you don't understand, and we will explain it.

In general, chiropractic treatment includes examination, taking of x-rays, manipulation/adjustment, and application of physical therapy modalities. Although their occurrence is extremely remote, some risks are known to be associated with these procedures. These include:

1) Stroke: is the most serious problem associated with spinal manipulation. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death (1 in 20 million). Spinal manipulations have been associated with strokes that arise from the vertebral artery (located in the neck vertebrae). (This problem occurs so rarely that there is no conclusive data to quantify probability.)

2) Disc Herniations: that create pressure on the spinal nerve or spinal cord are frequently successfully treated by chiropractors. Rarely, treatment may aggravate the problem, resulting in increased low back pain, radicular pain and numbness of a transient nature, Residuals may last for a few days but seldom for longer periods of time.

3) Soft tissue injury: Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, treatment may injure some muscle and ligament fibers. The result is temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient.

4) Rib fractures: The ribs are found only in the thoracic spine or middle back. Rarely, a manipulation will fracture a rib bone. This occurs only on patients who have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients carefully, especially those who have indications of osteoporosis on their x-rays.

I hereby authorize and direct Bart Sellers D.C., LLC, together with associates and assistants of his choice, to provide chiropractic treatment including examination/diagnostics, spinal manipulation/adjustment, carious modes of physical therapy, x-rays and any additional procedures or services that may be deemed necessary or reasonable. This treatment has been explained to me, and alternative methods of treatment (if any) have also been addressed. I have read and understand all information set forth in this document, including any attachments. I acknowledge that I have had the opportunity to ask any questions about the contemplated procedure and that my questions have been answered to my satisfaction. This authorization for and consent to chiropractic treatment is and shall remain valid until revoked.

Patient's name________________________________ **Date**_________________________
Signature of patient / guardian____

Relationship to patient___________________________________

AUTHORIZATION, ASSIGNMENT & RELEASE FORM

In consideration of your services for my care, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.

2. I authorize the direct payment to you of any sum that I now or hereafter owe you, by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges for your services.

3. In event any insurance company, obligated by contractual agreement to make payment to me or to you for the charges incurred for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute and take action in my name as you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit. However it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe and agree to pay to you.

4. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.

5. This Authorization for assignment will be in continual effort until revoked by both parties.

________________________________ ________________

PATIENT’S SIGNATURE DATE

CHIROPRACTIC ASSOCIATES OF MANDEVILLE

221 Saint Ann Drive, Suite 2
Mandeville, LA 70471
Telephone (985) 624-9888
Fax (985) 624-2572

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and clinical records to contact you with appointment reminders, information concerning treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home or work, a message will be left on your answering machine, with a family member, friend, co-worker or employer. In addition, by signing this form you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke authorization to us at anytime; however, our revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at anytime. (164.524)

This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

______________________ Patient name printed	______________________ Date
______________________ Patient signature	______________________ Authorized provider representative
______________________ Personal representative printed	______________________ Personal representative signature

____
Description of personal representative’s authority to act for patient.

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FUND RAISING AUTHORIZATION

From time to time our practice raises money for community causes. Your chiropractor and members of the practice staff may need to use your name and address to contact you to request your assistance with these fund raising efforts. We are specifically requesting authorization to mail out post cards to you for the following purpose; assisting the food bank in supplying food to the needy, supplying Thanksgiving food and Christmas gifts to those in need or any fund raising endeavor done in cooperation with the Chiropractic Associates of Mandeville.

The post cards that are mailed states that if you make a donation for our cause (which can be can goods or money) you will receive a free adjustment on that day. You may revoke this authorization to us at anytime; however, our revocation must be in writing and mailed to us at our office address.

Information that we use based on authorization you are giving us is used for our mailing purposes only. Your information will not be sold or disclosed to any other party at any time for fund raising purposes

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you.

You may inspect or copy the information that we use to contact you. (164.524)

This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use my mailing information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

____
Patient name printed

____
Date

____
Patient signature

____
Personal representative printed

____
Personal representative signature

BART SELLERS, D.C.
Chiropractic Associates of Mandeville

HEALTH QUESTIONNAIRE

NAME____________________________ **DATE**_____________

Please circle the fitting answer.

1. Approximately how many servings of **raw** (**uncooked** and **unprocessed**) **fruit** do you eat on an average **each day**? (1serving = 1medium apple or orange or ½ cup chopped fruit)
   Less than 1   1   2   3   4 or more

2. Approximately how many servings of **raw** (**uncooked** and **unprocessed**) **vegetables** do you eat on an average **each day**? (1serving = 1 cup raw leafy vegetables or ½ cup chopped other vegetables)
   Less than 1   1   2   3   4 or more

3. Do you usually eat breakfast in the morning?
   never   once a week   twice a week   three times a week   4 or more times a week

4. About how many times **each week** do you eat a meal from a **"fast food"** restaurant?
   none   1   2   3   4 or more

5. About how many **glasses of water** do you drink on average **each day**? (1glass = 8 ozs)
   less than 1   1-2   3-4   5-6   7 or more

6. About how many **carbonated soft drinks** do you drink on average **each day**? (1=12ozs)
   less than 1   1   2   3   4 or more

7. Are you currently taking any kind of **nutritional supplement**?
   No
   Yes: vitamin/mineral supplement
   Yes: other supplement (please specify)
   ____

8. During the **last completed year**, how many **days of work did you miss** due to illness or doctor visits?
   none   1-2   3-4   5-6   7 or more

9. How would you characterize your ability to **concentrate and pay attention**?
   poor attention   fair attention   normal attention   above avgerage attention   excellent attention

10. How many days do you exercise **each week**?
    never   once a week   twice a week   three times a week   4 or more times a week

11. Whether or not you exercise, how would you describe your **overall level of physical activity**?
    sedentary/ very inactive   somewhat inactive   not especially active or inactive   active   very active