Back 2 Back Chiropractic, PLLC

www.back2back.com

Cass City - Caseville

WELCOME TO OUR OFFICE!

The doctors at Back 2 Back Chiropractic welcome you and want to provide you with the best possible care.

INSURANCE

This office will process your insurance forms upon request. We will do our utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that, in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full.

All fees are due at the time of service. This office accepts cash, check and credit card.
If this visit is WORK or AUTO related, please notify the front desk

_____
Your Name

_____
Primary Address

_____
City, State and Zip

Date of Birth _____

Sex: MALE FEMALE

Race: White Latino
African American Other:_____

Marital Status:
Married Single Divorced Widow

Social Security: _____-_____-_____

Telephone
Home_____
Work _____
Cell _____

Preferred Language: _____

Email: _____@_____

Age _____yrs Height ____ ft ____in

Weight _____lbs Right / Left Handed

Occupation:_____

Employer:_____

Is this visit work-related? Yes No

Emergency Contact, Name & Number: _____

Name and DOB of the insured (name on the card, if not you):
Name:_____DOB:_____
Relationship to you (Spouse, parent):_____
Who is the insurance through? (**Employer Name**, Medicare, Medicaid, other):_____

How did you hear about us? (please indicate)
__ Friend __ Family __ Advertisement __ Phone Book __ Internet __Doctor
__ Other (please list): _____

It is *your* responsibility to know your coverage benefits, co-pays and deductible. Much of this information can be found by calling your carrier or by reading the EOBs that you receive from your carrier following service. If you receive a statement from this office and you feel there is an error, please do not hesitate to give us a call.

Back 2 Back Chiropractic, PLLC
INFORMED CONSENT & PRIVACY NOTICE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me or on the patient named below, for whom I am legally responsible.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of the spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptoms, disease or condition as a result of treatment in the clinic. I understand that the chiropractor will use his or her hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click." It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he or she feels at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with similar cases.

I have an opportunity to discuss the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited, fractures, disc injuries, strokes, dislocation and sprains.

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health, history, symptoms, examination and test, diagnosis, treatment, and any part for future care or treatments. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided. I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided or forward a copy in via- e-mail at my request. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have a right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already take action in reliance thereon.

I have read, or have had read to me, the Informed Consent to Chiropractic Adjustments and Care. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above – named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Assignment of Insurance Benefits

I authorize and direct that payment be made directly to:

Vollmar-Yeager Chiropractic, PLLC
DBA Back 2 Back Chiropractic, PLLC
4456 Seeger Street Cass City, MI 48726

for any and all insurance benefits or reimbursement for services rendered by him/her which amounts would otherwise be payable to me under any insurance or pre-paid health care plan. I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan or Medicare. ***I understand that there is no guarantee that my insurance company(s) or pre-paid health plan, including Medicaid, will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges designated as patient responsibility. This office reserves the right to assess/collect monthly late fees for any unpaid balance exceeding 30 days after the last date of service. In the event the account becomes delinquent, we reserve the right to incorporate any fees for recovering the owed amount.***

Sign below to acknowledge the above:

Name: _____ Signature: _____ Date: _____

Authorization for the Release of Protected Health Information to:

Back 2 Back Chiropractic, PLLC
4456 Seeger St, Cass City, MI 48726
Phone 989-872-2737 Fax 989-872-2740

Patient Name _____ Date of Birth _____

I request and authorize the entities and individuals listed above to release my protected health information and send to Back 2 Back Chiropractic, PLLC.

Signature: _____ Date: _____

MASSAGE CANCELLATION POLICY:

All massages require cancellation 24 hours in advance. Failure to do so will result in a $30 fee applied to the client's account.

Initial to acknowledge:_____

Health History – Tell Us About Your Health

Have you ever been diagnosed with the following: (Please Circle)

AID/HIV	High Blood Pressure	Stroke
Anxiety	High Cholesterol	Thyroid Problems
Arthritis	Kidney Disease	Tuberculosis
Bleeding Disorder	Liver Disease	Tumors/Growths
Breast Lump	Migraines	Other:
Cancer	Multiple Sclerosis	_____
Diabetes	Mononucleosis	_____
Depression	Osteoporosis	_____
Epilepsy	Pacemaker	_____
Gout	Pinched Nerve	_____
Heart Disease	Polio	
Hepatitis	Prostate Problem	
Herniated Disc	Rheumatoid Arthritis	

Do you have any **allergies** to **medication** or **food**? **Y / N WHAT?:_____**

Family History – Tell Us About Your Family's Health

Does anyone in your family suffer from: (Please Circle)

High blood pressure	Stroke
Diabetes	Circulation Problems
Cancer	Autoimmune disease
Thyroid disease	RA/Lupus/Reynauds/Psoriasis)
Osteoporosis	Digestive Problems
Rheumatoid arthritis	Lung Disease
Heart Problems	Back Pain
Kidney Disease	Neck Pain

Review Of Systems –Tell Us About Your Body Systems

Please circle any problems you have had in the past 6 months

Muscles/Skeleton
Lower Back Pain
Neck Pain
Joint Pain
Stiffness
Walking Problems

Nervous System
Numbness
Paralysis
Dizziness /Confusion
Tingling in Leg/Arm
Stress

General
Headaches
Loss of Sleep
Fever

Gastrointestinal
Excessive Thirst
Vomiting
Diarrhea / Constipation
Gall Bladder Trouble
Abdominal Cramps
Heartburn
Black/Bloody Stools
Bowel Trouble

Urinary
Bladder Trouble
Painful Urination
Frequent Urination
Discolored Urine

Heart/Lungs
Chest Pain
Shortness of Breath
High Blood Pressure
Heart Problems
Ankle Swelling

Eyes, Ears, Nose & Throat
Vision Trouble
Dental Trouble
Earaches
Hearing Difficulty
Sore Throat

Social History – Tell Us About Your Everyday Life

Do you drink Alcohol? Y / N

How Often? _____drinks/week

Do you use Tobacco? Y / N How many packs/day? _____ How Long?_____

If you have quit either, how long ago? _____y/m/d

Do you use cocaine, marijuana or other drugs? Y / N What? _____

Do you exercise? Y / N Type: Walking Running Swimming Biking Weights Aerobics

Other_____ How Often? _____ times per week for _____ minutes

Are you currently employed? Y / N

If NO, are you: Retired Unemployed Disabled Home-Maker Other

Where?_____ Address:_____

What do you do? _____ How Long? _____

Is the reason for this visit Work or Auto Accident related? Y / N_____

If the problem you are seeking treatment for is work-related or auto-accident related, you must fill out a form related to the incident. Please ask the front desk.

Medications

Please list medications, supplements, herbs or other substances you are taking

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Trauma and Surgery History

Please list most recent first. List Date, What Happened and Outcome

Example: 4/1/2010 Total hip replacement Good results

1. _____

2. _____

3. _____

4. _____

5. _____

Main Complaint

The main problem is _____
The pain is on the right / left / middle / both sides of the _____
The pain first started: _____
It began: Gradually Suddenly After Trauma/Injury
What Happened?_____
What makes your symptoms worse? Standing, walking, sitting, bending, coughing, sneezing, other: _____
What makes your symptoms better? Ice, heat, pills, sitting, standing, other:
_____
My pain feels (circle any): dull sharp achy numb tingling burning shooting
Does the pain or numbness travel to another area? (e.g.: down arm or leg)
_____
How often is the pain present? Constantly intermittently occasionally frequently
If this is a recurrence, how long does it generally last? hours days weeks months years

Circle Pain Level **(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe)**

Additional Complaint

My second problem is _____
The pain is on the right / left / middle / both sides of the _____
The pain first started: _____
It began: Gradually Suddenly After Trauma/Injury
What Happened?_____
What makes your symptoms worse? Standing, walking, sitting, bending, coughing, sneezing, other: _____
What makes your symptoms better? Ice, heat, pills, sitting, standing, other:
_____
My pain feels (circle any): dull sharp achy numb tingling burning shooting
Does the pain or numbness travel to another area? (e.g.: down arm or leg)
_____
How often is the pain present? Constantly intermittently occasionally frequently
If this is a recurrence, how long does it generally last? hours days weeks months years

Circle Pain Level **(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe)**

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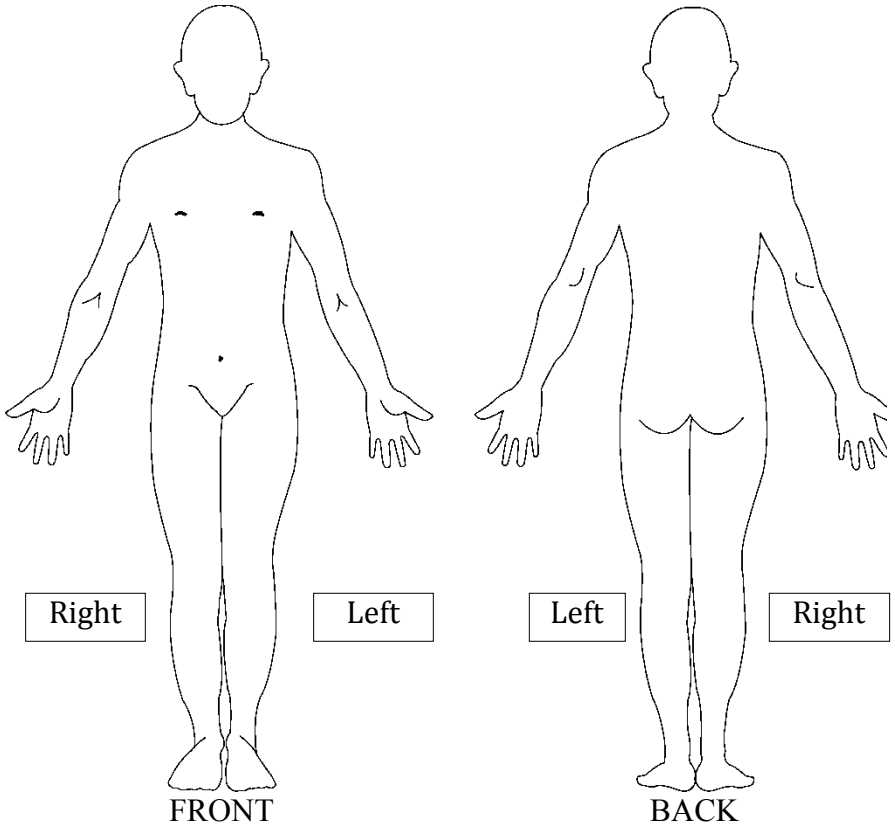
WHERE DOES IT HURT?

If you have more than one complain, number them by severity (1= biggest problem, 2= next worst problem, etc)

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	00000	xxxxx	*****	/ / / / /

Please mark on the pain scale from Zero to 10 the pain you feel with this condition.
10 being the worst pain you have felt with this condition.



Neck/Shoulder Pain

On a scale of zero to 10, I rate my discomfort as follows:

(_____)

0 **10**

no pain **severe pain**

Middle Back Pain

On a scale of zero to 10, I rate my discomfort as follows:

(_____)

0 **10**

no pain **severe pain**

Low Back/Leg Pain

On a scale of zero to 10, I rate my discomfort as follows:

(_____)

0 **10**

no pain **severe pain**

List any other symptoms:

_____

_____

_____

_____

_____

_____