Advanced Chiropractic & Spine Center of Souderton

Dr. Keith M. Miller

655 East Broad Street **Souderton, PA 18964**
(215) 703-9999 Phone **(215) 703-9897 Fax**
DrMiller@Drspine.net **www.DrSpine.net**

NAME: _____ **SUFFIX** **DATE:** _____ /_____ /_____

STREET ADDRESS: _____ **APT/SUITE#:** _____

CITY: _____ **STATE:**_____ **ZIP CODE:** _____

MOBILE #: (_____)-_____-_____ **WORK #:** (_____)-_____-_____ **EXT:**_____

HOME #: (_____)-_____-_____ **EMAIL:** _____

BIRTHDATE: _____ /_____ /_____ **AGE:** _____ **ACTIVE/RETIRED MILITARY:** YES / NO

MARITAL STATUS: SINGLE / MARRIED / SEPERATED / DIVORCED / WIDOWED

EMPLOYMENT STATUS: EMPLOYED / UNEMPLOYED / SELF EMPLOYED

EMPLOYER: _____ **JOB TITLE:** _____

EMERGENCY CONTACT: _____ **RELATION TO YOU:** _____

PHONE #: (_____)-_____-_____

We would like to thank the patient who referred you to our office; whom should we thank for their kind referral? If you were not referred by another patient, how did you hear about our office?

_____

Welcome to Advanced Chiropractic & Spine Center

It is our goal in this office to give you, our new patient, the best possible overall care that we are able to provide. In order to achieve this goal we must first spend some time collecting pertinent information about your problem or problems. Please be as open, honest and specific as you can, as it allows us to give you the most accurate and complete treatment for your condition. All information provided is kept strictly confidential, except for insurance or documentation purposes. Should you require assistance at any time filling this out, do not hesitate to ask a member of our health and wellness team for help.

Thank you for choosing our office, and please tell a friend! ☺

What is THE MAJOR complaint(s) that brought you into our office today?

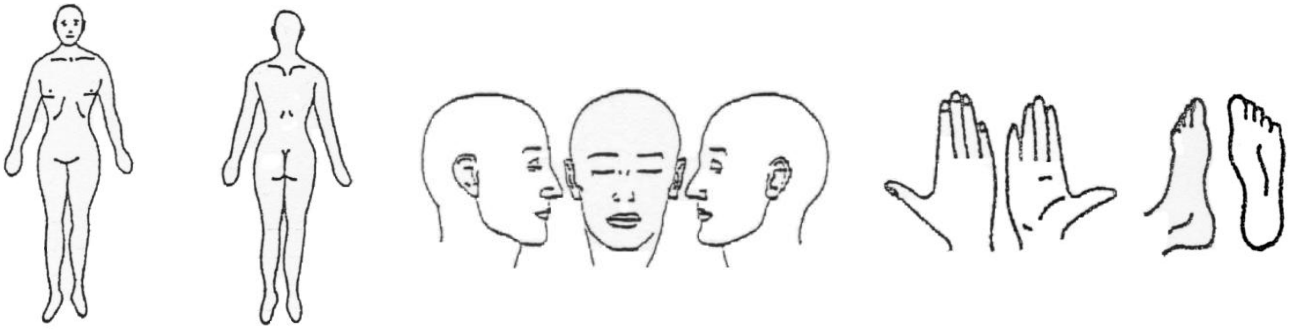
_____

Is your injury due to an auto accident OR work related accident?

AUTO INJURY:_____ DATE OF ACCIDENT: ___ /___ /_____ REPORT/CLAIM FILED: Y / N
WORK INJURY:_____ DATE OF ACCIDENT: ___ /___ /_____ REPORT/CLAIM FILED: Y / N

Have you EVER seen a chiropractor before: Y / N **If YES, who:**_____
My current Primary Care Physician is:_____ **Phone#:** (_____)-_____-_____
I am / may be pregnant: Y / N **If YES, are you under a doctor's care:**_____

Please mark the diagrams where you feel any Pain, Numbness and/or Tingling



Which of the following apply to you presently: (Please X all that apply)

	PAIN		NUMBNESS		TINGLING	
	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT
HEAD						
NECK						
UPPER BACK						
MID BACK						
LOWER BACK						
SHOULDER						
ARM						
FOREARM						
HANDS/FINGERS						
BUTTOCK						
HIP						
THIGH						
LEG						
FOOT						

My pain and symptoms may be aggravated by the following:

Coughing: ____ Sneezing: ____ Straining on toilet: ____ Reaching: ___ Lifting: ____ Sitting: ____
Neck movement: ____ Bend at waist: ____ Standing: ____ Walking: ____ Weather: ____ Other: ____

Since my symptoms began, I have noticed a change in my:

Bowel Functions: ____ Bladder Functions: ____ Ability to maintain an erection: ____

The following questions are to help us assess your present total health. The questions may or may not ***seem*** to have anything to do with your illness, condition, or accident… however injuries to your neck, head, and back can often directly impact your present health. *Place an **X** if you are now (**or in the past six months**) suffering from any of the following:*

GENERAL

Chills: _____ Fatigue: _____ Weight Change: ____ Weakness: _____ Night sweats: _____ Fever: _____

SKIN

Redness: _____ Rash: _____ Itching: _____ Eczema: _____ Hair changes: _____ Nail changes: _____
Skin color changes: _____ Abnormal growths/Moles: _____ Other: _____

NEUROLOGIC

Fainting: _____ Headache: _____ Migraine: _____ Convulsion: ____ Dizziness: _____ Seizure: _____

EYES

Vision Problems: R / L Eye Pain: R / L Discharge/Leaking: R / L Auras/Halos: R / L

EARS

Hearing Problems: R / L Ear Pain: R / L Discharge/Leaking: R / L Ringing: R / L

NOSE

Allergies: _____ Sinus Infection: _____ Pain: _____ Bleeding: _____ Lose of Smell: _____

MOUTH/THROAT

Blisters/Sores: _____ Bleeding: _____ Lose of Taste: _____ Strange Tastes: _____ Discharge: _____

HEART/LUNGS

Cough: _____ Wheezing: _____ Difficulty Breathing: _____ Chest Pain: _____ Palpitations: _____
Murmur: _____ Fast Heartbeat: _____ Slow Heartbeat: _____ Swollen Limbs: _____ Blue Limbs: _____

BREASTS

Lump(s) in Breast(s) : _____ Pain/Soreness: _____ Redness: _____
Itching: _____ Dimpling: _____ Discharge: _____

STOMACH/INTESTINES/DIGESTION

Decreased Appetite: _____ Increased Appetite: _____ Abdominal Pains: _____ Reflux: _____
Vomiting: _____ Diarrhea: _____ Gas/Bloating: _____

REPRODUCTIVE FUNCTION/URINATION/BOWEL FUNCTION

Cannot Hold Urine: _____ Frequent urination: _____ Burning Urination: _____
Constipation: _____ Painful/Bloody Stool: _____ Impotence: _____ Sterility: _____
Irregular menstruation: _____ Painful Menstruation: _____ Abnormal Vaginal Bleeding: _____

GLANDULAR

Hot/Cold Intolerance: _____ Goiter: _____ Shakes/Tremors: _____ Sugar In Urine: _____

MENTAL

Depression: _____ Anxiety: _____ Mood Swings: _____ Phobias: _____ Memory Loss: _____

Which of the following illnesses/conditions have you *EVER* had?

Arthritis: _____	Asthma: _____	Heart Problems: _____	Hay Fever: _____
Allergies: _____	Tuberculosis: _____	Diabetes: _____	Epilepsy: _____
Thyroid Problems: _____	High Blood Pressure: _____	Low Blood Pressure: _____	Sinus Problems: _____
Ulcers: _____	Rheumatic Fever: _____	Polio: _____	Cancer: _____
Spinal Disc Disease: _____	Multiple Sclerosis: _____	Scoliosis: _____	Serious Injury: _____
Bone Fracture: _____	Dislocated Joints: _____	Prostate Problems: _____	Blood Disorder: _____
Kidney Problems: _____	AIDS/HIV: _____	Other:_____	
	Other Sexually Transmitted Infection: _____	_____	

If any member of your IMMEDIATE family has any illness/condition listed above, please list their relation to you and condition here:_____
_____
_____

SOCIAL HISTORY

I smoke: Never: _____ ½ Pack a day or Less: _____ ½ - 1 Pack a day: _____ A Pack or more: _____

I drink alcohol: Never: _____ With meals: _____ Socially: _____ Often: _____ Daily: _____

I exercise: Never: _____ 1x-2x per week: _____ 2x-4x per week: _____ 4x+ per week: _____

Doing: Aerobic: _____ Weight Training: _____ Running: _____ Other: _____

My normal hobbies, sports, activities & family responsibilities include:

_____

My current condition(s) / problem(s) keep me from doing the following:

_____

Please Read the following agreement and sign date below:

I understand and agree that both health and accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that Advanced Chiropractic & Spine Center, Inc. and its affiliates will prepare any necessary reports and forms to assist me in my collections from the insurance company, and that any amount authorized to be paid directly to this office will be credited to my account and not paid to me directly. Additionally, any payments made to me directly by an insurance agent / carrier for the purpose of covering billed services of this office will be signed over / remitted within 14 business days if the billed amount was not already prepaid. If your injuries are a result of an automobile accident(s) or workman's compensation claim, and a lawyer(s) was\were retained, I authorize that all proceeds of claims or suits be paid directly to the care provider(s) immediately upon receipt of settlement before any other payout related to this claim. I clearly understand and agree that all services rendered to 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/or treatment, any fees for professional services rendered me will become immediately due and payable.

_____ _____ _____ /_____ /_____

PRINTED NAME (patient or guardian) SIGNATURE DATE

Electronic Health Records Intake Form

In compliance with mandatory 2018 requirements for the government EHR incentive program

First Name: _____ **Last Name:** _____

Email Address: _____

Preferred Method of Communication (circle one):	PHONE	EMAIL	USPS MAIL	
Gender (circle one):	MALE	FEMALE	DECLINE TO SPECIFY	
Smoking Status (circle one):	EVERY DAY SMOKER	LIGHT SMOKER	EX-SMOKER (QUIT)	NEVER SMOKED

CMS & the government EHR incentive programs require health providers to report BOTH race and ethnicity

Race (circle one):	WHITE/ CAUCASIAN	AFRICAN AMERICAN	AMERICAN INDIAN OR ALASKA NATIVE	PACIFIC ISLANDER
	NATIVE HAWAIIAN	ASIAN	OTHER:_____	I DECLINE TO ANSWER
Ethnicity (circle one):	HISPANIC OR LATINO	NOT HISPANIC/ LATINO	OTHER:_____	I DECLINE TO ANSWER

Are you currently taking any Medications?
Please include regularly taken over the counter medications

Medication Name	Dosage & Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date
		____ /_____ /_____
		____ /_____ /_____
		____ /_____ /_____

Do you have a PACEMAKER? Y / N Or ANY heart condition?_____

HEIGHT: _____	WEIGHT: _____	BLOOD PRESSURE: _____

_____ _____ ____ /_____ /_____

PRINTED NAME (patient or guardian) SIGNATURE DATE

Office Policies Summary - 2024

GENERAL POLICIES

- Payment is due at time of service unless arrangements have been made prior with the office billing coordinator.
- Office staff will always try their best to collect from your insurance company; however, payment for services is always the responsibility of the patient
- Please arrive at your scheduled appointment time. If you are going to be more than 10 minutes early or late please contact the office to ensure there is room in our schedule at that time. Early arrival *does not guarantee* we can see you sooner.
- If you are ***more than 10 minutes late***, we reserve the ability to appropriately adjust your therapies so we can accommodate you between other scheduled patients.

INSURANCE & PAYMENT POLICIES

- I understand that the patient, not the office, is responsible for getting a referral. Office staff will do their best to assist in this process.
- If my insurance requires a referral / pre-authorization and it cannot be obtained, I understand that I will be charged directly out of pocket at the current self-pay rate for these services.
- If my insurance has Deductible in 2024, that deductible must be met before benefits are paid to the office. I understand that ACSC will bill me a minimum of $50 towards the patient responsibility / deductible at the time of each service date pending the Insurance Processing and Explanation of Benefits. In the *rare event* of an overpayment, the office will contact within 60 days to notice of any over payments.
- I am responsible for immediately informing staff of any changes to my insurance plan and am ultimately responsible for any services in the office that remain unpaid due to lapse in coverage.

Patient Fees:

- $70 →Minimum New Patient Exam
- $55 →Minimum Chiropractic Treatment
- $50 →Minimum Re-Exam (Out of office 6 months-1 year)
- $65 →Minimum Re-Exam w/ Updated History (Out of office over 1 year)
- $35 →Soft Tissue Massage Therapy (Per half hour)

SOFT TISSUE & MASSAGE THERAPIST APPOINTMENTS

- If I cancel my soft tissue therapy appointment without giving >24 hour notice and/or no call no show for the appointment, I will be charged a missed / canceled appointment fee based on the length of appointment.
- If I am late to my appointment, I surrender that time and understand that the therapist cannot go into another patients scheduled time.
- I am responsible for the full cost of the scheduled appointment regardless of check-in time.

***** Please see our staff if you have any questions/concerns *****
***** regarding these or any other office policies ****

_____	_____	_____
PRINTED Name (Or guardian)	Signature	Date
_____	_____	_____
WITNESS Name (ACSC Staff)	Signature	Date

HIPAA Privacy Disclosure & Informed Consent to Chiropractic Treatment

PRIVACY NOTICE: I acknowledge that I have the right to request either a long full version of the practices privacy policy or a summary short form at any time. I am aware that the office has a privacy policy that complies with the 2003 federal HIPAA guidelines, and by my signature accept and acknowledge my rights and conditions under this posted and available policy upon request. Should you wish to have a copy printed for you please request it at anytime. Your signature below accepts our HIPAA policies.

The nature of chiropractic treatment: The doctor will use his/her hands or use a mechanical device / table in order to move your joints with chiropractic "adjustment" or "manipulation". You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint(s). Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, x-ray, digital imaging, therapeutic ultrasound, decompression, axial traction, extension compression traction, rehabilitation, exercising and stretching, inter-segmental traction, flexion-distraction traction, therapy ball, massage therapy, soft tissue muscle therapy, various topical pain relief gels creams and/or lotions, etc may also be used in conjunction with your treatment.

Possible Risks: I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. As with any health care procedure, complications are possible following a chiropractic manipulation / ancillary therapies. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications. Complications, while extremely rare, could include but are not limited to: fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, and injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck in *extremely rare* instances of manipulation.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", far less often then complications seen from the taking an NSAID or Aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated according to the ACA in 2014 as one in 5,850,000 million treatments, and can be even further reduced by proper screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare", but can occur at any time.

Other treatment options & referrals which could be considered may include the following:

- *Over-the-counter analgesics*. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases. Medications such as NSAIDS/Aspirin have been shown to cause heart damage & death at a risk rate of 153 in 1,000,000 *(Am J Gastroenterology 2005, Aug;100(8):1685-93)*
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics / narcotics. Risks of these drugs include a multitude of undesirable side effects and patient dependence / addiction in a significant number of cases and even death.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases. Many patients treated in hospitals leave with conditions new / worse than their original complaint.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases. Surgery can result in increased symptoms, permanent loss of function or death.

Risks of remaining untreated: Delay of proper chiropractic treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment can complicate the condition and make future care more difficult. Patients **who do not follow** their recommended chiropractic treatment plan may revert to their original symptoms, or even become worse from failing to finish treatment.

Informed consent:

I have read the explanation above of chiropractic treatment & modalities \ referral \ options. I know have the opportunity to have any questions answered to my satisfaction at any time. I have fully evaluated the risks and benefits of undergoing treatment. I freely decide to undergo the recommended treatment and/or procedures and herby give my full consent to treatment and release the office and staff from future liability which may result from care. I accept these risks for the potential benefits of treatment in this office. I accept these risks fully, without coercion, and give my informed consent.

_____	_____	_____
PRINTED Name (Or guardian)	Signature	Date
_____	_____	_____
WITNESS Name (ACSC Staff)	Signature	Date