PI Intake

Please fill in or circle where appropriate

Name: _____ **Date of Injury:**_____ **Sex:** M F

Were you the: Passenger Driver

Direction of Impact: Front Right Left Rear **Where were you facing when collision occurred:** R L Up Down Straight Ahead

Wearing seatbelt: Y N **Airbags deploy:** Y N **Did your head hit head rest, window etc.?:**_____

Were you aware of collision about to happen: Y N

Main areas of Complaint/Pain:

1. _____ 2. _____ 3._____

4 _____ 5. _____ 6. _____

Rated 0-10 (10 is the worst, 0 is best, what is your <u>current</u> pain level (0-10) _____

How frequent is the pain? _____% of the time **How bad is it at its worst?**_____

At its best: _____ **Did it start:** Gradually Suddenly

When did discomfort begin? _____Days ago **Symptoms have gotten:** Better Worse Same

Worse: Standing Sitting Lying Down Bending Carrying Coughing Dressing Driving Lifting Moving Sneezing Twisting Walking

Better: Standing Sitting Lying Down Resting Heat Ibuprofen Ice Stretching Walking

Describe Pain: Sore Aching Dull Sharp Shooting Throbbing Tight Tingling Numb Burning

Worse: Morning Evening Afternoon Sleeping

Is your pain/discomfort: Superficial (on the surface) or Deep?

History of Trauma: _____ **History of Surgery:** _____

For this accident did you go to: Hospital/ ER/ Urgent Care/ Primary Doctor/ None: if so where? _____

Dates of missed work: _____

Are You: Dizzy Fatigued Nauseous **Treatment for this Injury:** _____

Previous Chiropractic treatment: Yes No **For this Injury:** Yes No **Last Adjustment?** _____

Previous Physical Therapy? Yes No **For this Injury:** Yes No **Last PT visit?** _____

What kind of vehicle were you in? _____

What kind of vehicle did you hit/get hit by? _____

Does the pain shoot or radiating? Arm Shoulder Legs Ribs Head Other _____? Right Left?

Tobacco use: Y N **Alcohol:** Y N

BLUESTONE CHIROPRACTIC

Confidential Patient Case History

Date _____

Name _____ Home Phone_____ Cell Phone_____

Address _____ City _____ State_____ Zip _____

Age ____ Birth Date _____ Sex M F Marital Status M S W D Number of Children _____ SS#_____

Employer _____ Occupation _____ e-mail _____

Work Address _____ Work Phone _____

Name of Spouse _____Spouse's Work Phone _____

In Case of Emergency, please notify _____ Phone _____

How did you hear about our office? Friend _____ □ Phonebook □ Employer □ Internet □ Other

Please list complaints and date the condition started, starting with your major complaint.

Complaints	Date Started
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____

Is your condition getting worse? □ Yes □ No Is it Constant? □ Yes □ No Comes and Goes? □ Yes □ No
Have you seen other doctors for this condition? □ Yes □ No

Please list other doctors seen and approximate date seen (including primary care physician):

Doctor	Approximate Date Seen
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

Have you experienced any serious accidents or falls within the □ Past year? □ 5 years? □ Over 5 years □ Never

If you have experienced an accident, what type was it? □ Auto □ Work □ Home □ Leisure □ Sports □ Other _____

Briefly Explain: _____

Are you presently taking any medication? □ Yes □ No Please List _____

List Surgical procedures you have had and an approximate date.

Procedure	Date
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

Has any blood relative ever had:

	Who		Who
Cancer	_____	Stroke	_____
Diabetes	_____	Arteriosclerosis	_____
Heart Trouble	_____	Arthritis	_____
High Blood Pressure	_____	Spinal Curvature	_____

Check the following that you have had:

□ Alcoholism	□ Chorea	□ Gout	□ Multiple Sclerosis	□ Scarlet Fever
□ Anemia	□ Cold Sores	□ Heart Disease	□ Mumps	□ Stroke
□ Appendicitis	□ Diabetes	□ Influenza	□ Osteoporosis	□ Tuberculosis
□ Arteriosclerosis	□ Diptheria	□ Lumbago	□ Pleurisy	□ Typhoid Fever
□ Arthritis	□ Eczema	□ Measles	□ Pneumonia	□ Ulcers
□ Asthma	□ Emphysema	□ Migraines	□ Polio	□ Whooping Cough
□ Cancer	□ Epilepsy	□ Miscarriage	□ Rheumatic Fever	

Check the following symptoms you have had within the past year:

General
- □ Allergy
- □ Chills
- □ Convulsions
- □ Dizziness
- □ Fainting
- □ Fatigue
- □ Fever
- □ Headache
- □ Loss of Sleep
- □ Loss of weight
- □ Depression
- □ Neuralgia
- □ Sweats
- □ Tremors

Cardiovascular
- □ Chest pain
- □ Angina
- □High blood pressure
- □ Low blood pressure
- □ Poor circulation
- □ Rapid Heart beat
- □ Slow heart beat
- □ Ankle swelling

Muscle & Joint
- □ Arthritis
- □ Bursitis
- □ Foot trouble
- □ Hernia
- □ Low back pain
- □ Lumbago
- □ Neck Pain
- □ Shoulder Pain

Pain or numbness in:
- □ Shoulders
- □ Arms
- □ Elbows
- □ Hands
- □ Hips
- □ Legs
- □ Knees
- □ Feet
- □ Tailbone

- □ Poor Posture
- □ Sciatica
- □ Spinal Curvature
- □ Swollen joints

Eyes, Ears, & Nose
- □ Asthma
- □ Colds
- □ Crossed Eyes
- □ Deafness
- □ Dental Decay
- □ Ear Ache
- □ Ear Discharge
- □ Ear Noises
- □ Enlarged glands
- □ Enlarged thyroid
- □ Eye pain
- □ Failing vision
- □ Far sightedness
- □ Gum trouble
- □ Hay fever
- □ Hoarseness
- □ Nasal obstruction
- □ Near sightedness
- □ Nosebleeds
- □ Sinus Infection
- □ Sore throat
- □ Tonsillitis

Respiratory
- □ Chest pain
- □ Chronic cough
- □ Difficulty breathing
- □ Spitting up blood
- □ Spitting up phlegm
- □ Wheezing

Gastro-intestinal
- □ Belching or gas
- □ Crohn's disease
- □ Colitis
- □ Colon trouble
- □ Constipation
- □ Diarrhea
- □ Difficult Digestion
- □ Gall Bladder trouble
- □ Hemorrhoids
- □ Jaundice
- □ Liver trouble
- □ Nausea
- □ Stomach pain
- □ Poor appetite
- □ Vomiting
- □ Rectal pain

Skin
- □ Bruise easily
- □ Dryness
- □ Hives or allergy
- □ Itching
- □ Rashes
- □ Varicose Veins

Genito-urinary
- □ Bed wetting
- □ Blood in urine
- □ Frequent urination
- □ Bladder control
- □ Kidney infection
- □ Painful urination
- □ Prostate trouble

Women Only
- □ Cramps
- □ Excessive flow
- □ Hot Flashes
- □ Irregular cycles
- □ Menopause
- □ Painful Flow
- □ Vaginal Discharge

	Yes	No
Have you ever been knocked unconscious?	☐	☐
Do you use a cane or other support?	☐	☐
Have you been treated for a spine or nerve disorder?	☐	☐
Have you ever had a fractured bone?	☐	☐
Have you been hospitalized for anything other than surgery?	☐	☐
Do you smoke?	☐	☐
Do you now take vitamins or minerals?	☐	☐

Habits:

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Date of Last:

	< 6 months	6-18 months	>18 months	Never
Spinal Examination	☐	☐	☐	☐
Physical Examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest x-ray	☐	☐	☐	☐
Spinal x-ray	☐	☐	☐	☐
Dental x-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

Are you pregnant? ☐ Yes ☐ No
How many weeks? _____

Please check the type of care you desire so that we may be guided by your wishes when possible:

☐ I prefer the doctor to select the type of care he feels is best for me ☐ Maximum improvement ☐ Temporary relief

Are you insured? ☐ Yes ☐ No Company _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account upon receipt. However, 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 be immediately due and payable.

Patient's signature _____ Date _____

Guardian's Signature _____ Date _____

Bluestone Chiropractic Fee Disclosure Form

The below list of services and range of fees charged is designed to avoid any miscommunication. Consultations are always no charge.

Exam or E/M	$45 - $345	Electrical Muscle Stimulation	$35
Chiropractic Adjustment	$45 - $70	Soft Tissue/Trigger Point	$50
Extremity Adjustment	$45	Therapeutic Exercise	$60
Heat or Ice	$25	Neuromuscular Re-education	$55
		Home Management training	$55

Insurance companies dictate the ranges of fees we can charge, which they refer to as "reasonable and customary fees". When we bill these fees for services rendered, they will turn around and either reject them outright or cut them by 20-60%. Because of this game they like to play, it is imperative that we itemize everything we do in order to be fairly compensated. We never bill for services we did not perform, but we always bill for services that we did perform. In addition, for those insurance companies we are contracted with we are required to be bound by their fee schedule (no balance billing). However, on those dates that they do not pay for care, **we will bill the patient for the date of service.**

Some procedure codes that show up on a patient's EOB (explanation of benefits) have names that don't seem to make sense to the patient, and we are often questioned about them. In order to avoid confusion, we have compiled the following descriptors:

E/M codes – Termed an evaluation and management code, these are used to update and document a patient's progress. These are done every 10-12 visits and are not full exams or re-x-rays.

Extremity Adjustment – Chiropractic codes are used for spinal adjusting only. When any other adjustment is made (ex. shoulder, wrist, knee) it must be documented as a separate code.

Soft Tissue/Trigger point - This code is used for techniques designed to stimulate circulation and break down fibrotic scar tissue in the muscle. Ex. vibration, acupressure, trigger point pressure.

Therapeutic Exercise – This code can be used for an activity that actively contracts and elongates muscle tissue for the purpose of stretching, toning, or strengthening. This is often confused by patients who don't feel like they did "exercise." Ex. stretching with resistance, therabands, ball exercises.

Neuromuscular Re-education – Used for increasing balance and stabilization. Ex. wobble boards, ball stability movement, core stabilization program, flexion/distraction.

By signing this document, I am indicating that I have read and understood its content and that I will ultimately be financially responsible for services provided in this office.

X _____ X _____

Patient Bluestone Staff

BLUESTONE CHIROPRACTIC

INFORMED CONSENT

Chiropractic is a non-surgical, non-invasive procedure and has one of the safest records in health care. As with any health care specialty, we cannot promise a cure, but we will give you the best care possible and discuss any questions or concerns with you.

Patients may experience temporary symptoms such as an increase in soreness following a massage, manipulation or traction. In addition, physiotherapy such as ice, heat, ultrasound or electrical muscle stimulation may irritate the skin. There have been rare cases where adjustments may have aggravated a bulging or herniated disc or caused a rib fracture. On extremely rare occasions, adjustments to certain areas of the cervical spine have been related to a compromise of the vertebral artery and possible stroke symptomatology. The most recent studies (Journal of the CAA, Vol. 37, No 2, June 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments.

If you have any questions concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Patient Signature_____ Date_____

Parent/Legal Guardian Signature_____ Date_____

Notice of Privacy Practices

- We will use your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, and conducting health care operations.
- We have updated our electronic billing software to be HIPPA compliant.
- It is 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.
- 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.
- We will notify government authorities if we believe a patient is the victim of abuse, neglect, or domestic violence.
- We may be required to disclose to Federal officials or military authorities, health information necessary to complete an investigation related to public health or national security.
- We will not disclose your health information other than with your written authorization.

YOU HAVE THE RIGHT:

- To request restriction on certain uses and disclosures for your health information.
- To request that we communicate with you in a certain way.
- To read, review, and copy your health information, including your complete chart, X-rays, and billing records.
- To ask us to update or modify your records if you believe your health information records are incorrect or incomplete.
- To ask us for a description of how and where your health information was used by our office for any reason other than treatment, payment, or health operations.
- To obtain copies of this Notice of Privacy Practices.
- To express complaints to us or to the Secretary of Health & Human Services if you believe your privacy rights have been compromised.

Patient Acknowledgement:
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 you acknowledging your receipt of our policy by signing, dating, and returning this notice.

_____ _____

Patient Signature Date

RELEASE OF RECORDS

I,_____, hereby release my records to the offices of Robert F. Leibmann, D.C. My date of birth is _____.

Records requested:

X rays_____

X rays reports_____

MRI_____

MRI report_____

Diagnostic Imaging report _____

Laboratory analysis _____

Patient progress notes _____

Other _____

Patient Signature_____Date_____

Doctor Signature_____Date_____

_____Please fax records to _____.

Please call if reports/films are not at this location.

Thank you in advance for your prompt service.

BLUESTONE CHIROPRACTIC

NO CELL PHONE POLICY

Bluestone Chiropractic Group **does not** allow any cell phone usage. No cameras, no videos, and no phone calls. You may bring a set of head phones. If you need to take an emergency call, please step outside to take the call. This is out of respect and courtesy of all our patients and staff. Thank you for your cooperation.

I understand the no cell phone policy notice above and I agree to not use my cell phone while in Bluestone Chiropractic Group's office out of respect and courtesy for others.

_____

Patient Name (please print)

_____

Patient Signature

_____

Today's Date

Automobile Accident Questionnaire

Patient's Name _____ Today's Date _____
Date of Accident _____ Hour _____ □ AM □ PM
Location of accident: _____
Describe how accident happened in detail: _____
_____
_____
_____

In the Accident:

Were you the □ Driver □ Passenger □ Pedestrian Where were you seated in the vehicle? _____
Did you strike the other vehicle? □ Yes □ No Did the other vehicle strike you? □ Yes □ No
Were you struck from: □ Behind □ Front □ Left side □ Right side
Were traffic citations issued to: □ You □ Driver of your car □ Driver of other car □ None
Was your car heading: □ North □ South □ East □ West on _____ (street or highway)
Was the other car heading: □ North □ South □ East □ West on _____ (street or highway)

Were you aware of the impending impact/accident? □ Yes □ No
Were you wearing your seat belt? □ Yes □ No
Which way was your head facing upon impact: □ Straight ahead □ Turned around □ Up at mirror

Describe in detail your symptoms immediately following the accident: _____
_____
_____

Check symptoms you have had since the accident:

□ Headache	□ Irritability	□ Short breath	□ Loss of smell
□ Neck Pain	□ Lower back pain	□ Fatigue	□ Loss of taste
□ Neck stiffness	□ Chest pain	□ Depression	□ Diarrhea
□ Sleeping problems	□ Pins/needles in arms	□ Loss of memory	□ Constipation
□ Upper back pain	□ Pins/needles in legs	□ Ears ringing	□ Cold feet/hands
□ Shoulder pain	□ Numbness in fingers	□ Loss of balance	□ Upset stomach
□ Tension	□ Numbness in toes	□ Fainting	□ Sweats/fever

Symptoms Other than above: _____

Have you lost time from work? □ Yes □ No Dates from _____ to _____
Did you require hospitalization? □ Yes □ No □ Emergency Room Only
If hospitalized, date admitted _____ date discharged _____
Name of Hospital _____
Address: _____
Attending Physician: _____

Bluestone Chiropractic

Robert F. Leibmann, D.C.

DOCTOR'S LIEN

I do hereby authorize this doctor's office to furnish my attorney with complete records of the examination notes, treatment/SOAP notes, diagnostic testing results, prognosis, etc., in connection with the accident in which I was involved.

I do hereby grant a lien on my case to the doctor and hereby authorize and direct you, my attorney, to pay directly to the doctor all sums due and owed to him for all services rendered to me, both by reason of this accident and by reason of any other bills that are due his office. I further direct my attorney to withhold such sums from any settlement, judgment, or verdict as is required to fully protect said doctor. This lien shall apply to all sums collected in this case regardless of source. This includes, but is not limited to, liability insurance, homeowner's insurance, uninsured/underinsured motorist insurance, medical payment insurance, and personal injury protection insurance.

I fully understand that I am directly and fully responsible to said doctor for all bills submitted in connection with services rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of the doctor's awaiting payment. I also understand that such payment shall not be contingent upon any settlement, judgment, or verdict by which I may be compensated for the accident. I further understand that this lien shall neither be reduced by any "Common Fund Doctrine" nor any other equitable consideration such as the "Made Whole Doctrine" or claim of unjust enrichment.

Please acknowledge that you understand and agree to the contents of this document by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor, at his sole discretion, may not await payment and may direct me to immediately pay any outstanding balance. I have been further advised that my attorney's failure to cooperate does not invalidate the doctor's lien or limit his right to pursue payment directly from any settlement, judgment, or verdict for all sums as may be due and owing in connection with services rendered to me.

Dated _____ Patient's Signature _____

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above and further agrees to withhold and pay such sums from any settlement, judgment, or verdict as may be necessary to fully reimburse said doctor above named for all services rendered to the patient.

Dated _____ Attorney's Signature _____

Please date, sign and return one copy to doctor's office. Keep a copy for your records. A photocopy of this form shall be considered as valid and legally enforceable as the original.

2765 N Scottsdale Rd. #108 Scottsdale, AZ 85257 Telephone: 480-990-1818 Fax: 480-947-5797

BLUESTONE CHIROPRACTIC

DATE: _____

PATIENT: _____

DATE OF BIRTH: _____

DATE OF INJURY: _____

_____ I HAVE HEALTH INSURANCE WITH _____ AND **WOULD NOT** LIKE DR. LEIBMANN AND HIS ASSOCIATES TO BILL THE VISITS PERTAINING TO MY ACCIDENT CASE.

_____ I HAVE HEALTH INSURANCE WITH _____ AND **WOULD** LIKE DR. LEIBMANN AND HIS ASSOCIATES TO BILL THE VISITS PERTAINING TO MY ACCIDENT. PLEASE NOTE HEALTH INSURANCE WILL SUBROGATE (WILL WANT REIMBURSEMENT). ***PATIENT IS RESPONSIBLE FOR ALL DEDUCTIBLE AND COPAYS ASSOCIATED WITH THEIR HEALTH PLAN,*** THESE WILL NOT BE PLACED ON A LIEN. WE ARE UNABLE TO BILL MEDICARE FOR ACCIDENT RELATED INJURIES.

My Insurance Member ID# is: _____

_____ I DON'T HAVE HEALTH INSURANCE.

_____

Print Name

_____

Signature