Reisterstown Family Chiropractic **Dr. Howard M. Lipman**

Personal and Family Health History

File #:_____

About You:

Name:_____ Today's Date:_____
Date of Birth:_____ Age:_____ Sex: _____ Height:_____ Weight:_____
Physician's Name:_____ Physician's Phone #: _____
Who May we Thank for Referring You? _____
Home Address: _____
Home Phone #: _____ Work Phone #: _____
Cell Phone #: _____ E-Mail Address: _____
Occupation: _____ Employer: _____
Marital Status: Married Single Widowed Divorced Separated
○ I give you permission to send me Health Tips via Email

About Your Family:

Spouse's Name: _____ Spouse's Occupation: _____
How Many Children Do You Have?_____

	Patient	**Spouse**	**Child #1**	**Child#2**	**Child#3**
Circle All that Apply					
1. Was Your Birth Traumatic?	Y	Y	Y	Y	Y
2. Have You Fallen as a Child?	Y	Y	Y	Y	Y
3. Have You Fallen as an Adult?	Y	Y	Y	Y	Y
4. Have You Had a Car Accident?	Y	Y	Y	Y	Y
5. Have You Played Sports?	Y	Y	Y	Y	Y
6. Are You Stressed Out?	Y	Y	Y	Y	Y

What Brings You to Our Office?

Describe Your Symptoms: _____
_____
Date When Symptoms First Appeared: _____
Did it Begin: (circle) *Gradually* *Suddenly* *Progressed over Time*
Was this Problem Due to an Auto Accident or Work Related Injury? (circle) *Yes / No*
What Makes the Symptoms Worse? _____
Quality of Pain: (circle) *Dull/Achy* *Sharp/Stabbing* *Burning* *Throbbing* *Electrical*
Does the Pain Radiate into Your: (circle) *Arm* *Leg* *Head* *Does Not Radiate*
Do You Experience Numbness or Tingling? (circle) *Yes / No*
What Percent of the Time Do You Experience these Symptoms? *100%* *75%* *50%* *25%* *10%*

What Have You Already Tried to Resolve this Problem: (check ALL that apply)
☐ Over the Counter Drugs ☐ Prescription Drugs ☐ Physical Therapy ☐ Surgery
☐ Chiropractic ☐ Massage Therapy ☐ Acupuncture ☐ Nutritional Supplements

Patient Signature: _____ Date: _____

11710 Reisterstown Rd. Suite 205 * Reisterstown, MD 21136
(410 517-2400 * fax (410) 843-9117

Reisterstown Family Chiropractic

Dr. Howard M. Lipman

File #: _____

Medical History:

Check ANY of the Symptoms You have Noticed (◘ = Previously, □ = Now)

◘ □ Low Back pain/ Stiffness	◘ □ Auto Accidents	◘ □ Vision / Eye Problems	◘ □ Sports injuries
◘ □ Mid Back Pain /Stiffness	◘ □ Hi/Lo Blood Pressure	◘ □ Ear problems	◘ □ Frequent Colds / Flu's
◘ □ Upper Back Pain/Stiff	◘ □ Work injuries	◘ □ Nose / Sinus Problems	◘ □ Prostate Problems
◘ □ Neck Pain/Stiffness	◘ □ Other Accidents/Falls	◘ □ Throat Problems	◘ □ Female Problems / PMS
◘ □ Headaches	◘ □ Fractured Bones	◘ □ Thyroid Problems	◘ □ Incontinence
◘ □ Migraine	◘ □ Sore Achy Muscles	◘ □ Allergies	◘ □ Impotence
◘ □ Pain Radiating into Arm	◘ □ Tiredness / Fatigue	◘ □ Respiratory Problems	◘ □ Pain w / Coughing
◘ □ Numbness/Tingling Arm	◘ □ Dizziness	◘ □ Heart Problems	◘ □ Pain w / Sneezing
◘ □ Carpal Tunnel Syndrome	◘ □ Fainting	◘ □ Circulation Problems	◘ □ Pain @ Stools
◘ □ Shoulder Pain/Stiffness	◘ □ Stress	◘ □ Digestion Problems	◘ □ Ulcers
◘ □ Elbow Pain / Stiffness	◘ □ Tension	◘ □ Intestine Problems	◘ □ Cancer
◘ □ Wrist/Hand Pain Stiff	◘ □ Nervousness	◘ □ Colorectal Problems	◘ □ Restricts Exercise
◘ □ Hip Pain or Stiffness	◘ □ Irritability	◘ □ Liver / Gall Bladder	◘ □ Unable to Work
◘ □ Pain Radiating into Leg	◘ □ Anxiety	◘ □ Kidney Problems	◘ □ Poor Diet
◘ □ Knee Pain or Stiffness	◘ □ Concentration	◘ □ Diabetes/Hypoglycemia	◘ □ Inadequate Water Intake
◘ □ Ankle/Foot Pain/Stiff	◘ □ Mood Disorders	◘ □ Bladder Problems	◘ □ Inadequate Exercise
◘ □ Trouble Walking	◘ □ Depression	◘ □ Skin Problems	◘ □ No Energy
◘ □ Restricts Daily Activity	◘ □ Memory Loss	◘ □ Excessive Sweating	◘ □ Other _____

Please List ALL medications you are taking: _____

_____

Please list ALL Hospitalizations and Surgeries (with dates): _____

_____

Please list ALL Traumas (Sports Injuries, Automobile Accidents, Slips & Falls): _____

_____

_____

Please List ALL known Allergies: _____

_____

Do you have any Implants, Surgical Hardware, Pacemakers or Metallic Sutures? (circle if Yes)

Are You Pregnant? □ Yes □ No Date of Start of your last menstrual Cycle: _____

Have you ever been diagnosed with: □ Cancer □ Diabetes □ Cardiovascular Disease □ Stroke

Please list ALL dietary supplements you're taking: _____

_____

How many glasses of Water (per day) do you drink? _____

How many times a week do you exercise? _____How many hours of sleep do you get per day? _____

How would you rate your diet? (circle one) Poor ← 1 2 3 4 5 → Excellent

How would rate your overall energy? (circle one) Poor ← 1 2 3 4 5 → Excellent

How would you rate your Stress Levels? (circle one) Poor ← 1 2 3 4 5 → Excellent

Upon Completion of your fist visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Active Life Plans are designed to get you feeling better quickly and to help you and your family be as healthy as possible. Please Review the Active Life Plan Explanations prior to your Chiropractic Report so you can choose the level of Participation that supports you in reaching ALL your health goals.

As a result of my Chiropractic Care, I would like to (Please Check ALL that apply)

□ ***Feel Better Quickly*** □ ***Have a healthier Spine and Nervous System*** □ ***Live a healthier lifestyle***

Patient Signature _____ Date _____

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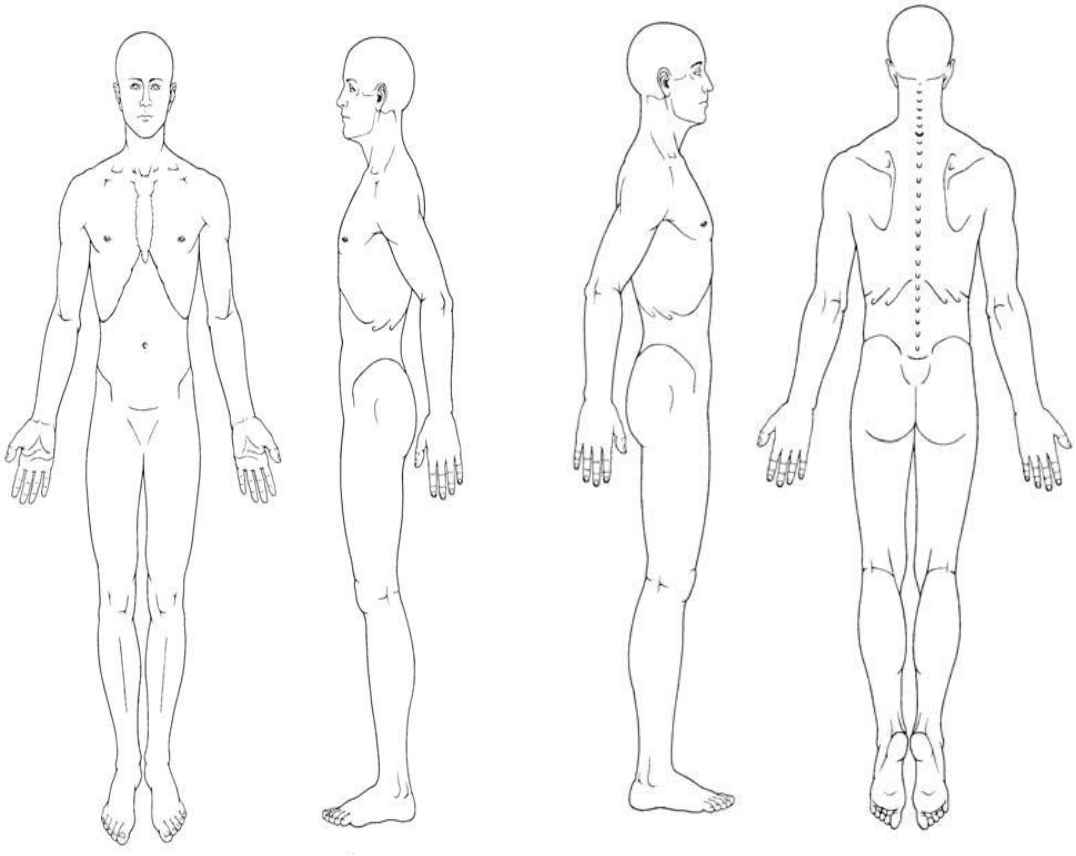
Location of Symptoms

Please indicate any areas of discomfort or pain on the body chart below. Mark the areas where you feel the described sensations using the following symbols. Please include all affected areas and mark areas of radiation (traveling pain)

Pain = **PPP** Tingling = **TTT**
Numbness = **NNN** Cramping = **CCC**
Burning = **BBB** Radiating Pain = /\/\/\/\/



Severity of Pain & Symptoms

Please Mark an "X" on the lines below to indicate the intensity of your Problem

1. Right Now: None ---------- Worst Possible
2. Average: None ---------- Worst Possible
3. At Worst: None ---------- Worst Possible

Patient Signature _____ Date _____

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File #:_____

Informed Consent to Chiropractic Treatment

The nature of Chiropractic treatment: The doctor will use his/her hands or a mechanical device to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as cold packs, electrical muscle stimulation, therapeutic ultrasound, flexion/distraction or therapeutic exercises may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic adjustment. Complications could include fractures of bone, muscular strain, ligamentous strain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. 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.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as the complications that are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury, or stroke, has been estimated from at one in one million to one in twenty million, and can even further be reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options (besides chiropractic) which could be considered may include the following:

- *Over- the-counter analgesics:* The risks of these medications include: irritation to the stomach, liver and kidneys as well as other side effects in a number of cases.

- *Medical care*: Typically, anti-inflammatory drugs, tranquilizers and analgesics are utilized. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

- *Hospitalization:* In conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.

- *Surgery:* In conjunction with medical care adds to the risks of adverse reaction to anesthesia, hospital acquired infections, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of 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 predictable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: Unusual risks are many times case specific and will be explained in detail if they occur.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. By signing below, I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

PATIENT SIGNATURE_____ DATE _____H

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Family Chiropractic

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Patient Privacy and Acknowledgement statement

File#_____

Part I – Acknowledgement Statement

I, the undersigned, hereby acknowledge that I have provided Reisterstown Family Chiropractic certain specific Protected Health Information, here after referred to as PHI. This information is provided by me, with the understanding that it will be used for these purposes only:
1-Diagnosis and treatment of my spinal complaints.
2-Billing my insurance carrier.
3-Provding requested information to my insurance carrier, this may include: Treatment notes, X-ray findings, examination or evaluation findings and reports.
4-Notifing me of future or missed appointments, by phone, U.S Postal service, or e-mail.
5- Announcing or informing me of Practice Events, such as Patient Appreciation Days, special promotion, etc.
6-By Subpoena, court order, or other Legal requiems
I understand that Reisterstown Family Chiropractic provides a sign in sheet daily. This sign in sheet is accessible to Staff members and other Patients entering this office seeking treatment. I also understand that Reisterstown Family Chiropractic displays the names of Patients that refer in other Patients in the Waiting Area. I agree that my name maybe used for this purpose should I refer in a Patient, unless I have provided a request to the contrary in writing.

Part II- My Rights as Patient

I have the right to:
1-Revoke this authorization at anytime, by submitting a written request for such to Reisterstown Family Chiropractic's Appointed Privacy Officer.
2-Request restriction of specific information or disclosure. This request must be made in writing and submitted to Reisterstown Family Chiropractic's Appointed Privacy Officer.
3-Inspect or copy any PHI. This request must be made in writing and submitted to Reisterstown Family Chiropractic's Appointed Privacy Officer.
4-Amend my PHI at anytime, as provided by law. All amendments will be made in writing.
5-Receive an accounting of any and all disclosures.

Part III- Reisterstown Family Chiropractic's Responsibilities

In accordance with Federal HIPAA Laws and Maryland State Privacy Laws, Reisterstown Family Chiropractic is required to:
1-Abide by all Federal and Maryland State Privacy laws and regulations.
2-Maintain my Chiropractic and financial records in a discrete and secure location within their office.
3-Notify me in writing of any changes to this acknowledgement and provide for my signature in a timely fashion an amended statement for my signature.

By subscribing my signature below, I acknowledge receipt of this notice and understand and agree to its terms.

_____ _____
(Signature of Patient or Guardian) (Date)

_____ _____
(Signature of Staff Witness) (Title)

My initials below signify that I have received a copy of my signed agreement for my personal records.

_____

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Reisterstown Family Chiropractic

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REISTERSTOWN FAMILY CHIROPRACTIC **File#: _____**
FINANCIAL POLICY

MAJOR MEDICAL GROUP / INDIVIDUAL HEALTH INSURANCE

Most insurance companies have benefits for Chiropractic treatment. The yearly deductible and co-payment will vary among insurance companies. It should be pointed out that our contract for services is with you, the patient. We work for you; not for your insurance company. Reisterstown Family Chiropractic provides the best services that we are capable of providing and expect that payment for those services will be made as promptly as possible. It is important, therefore, for you to become an informed consumer relative to your insurance coverage.

OFFICE POLICY

****1. As a courtesy to you, we will call to see if your health insurance policy includes Chiropractic benefits. We will notify you of the percentage that your policy covers and any limitations to the payments. If we are informed that you have not met your yearly deductible, this balance is required to be paid by you directly to our office. We will need a copy of your drivers' license and your insurance card to be kept on file in your numbered chart. In addition to our office verifying your insurance benefits, we require that you, the patient, call your insurance company to verify your own coverage. We will provide an Insurance Verification form, to be completed by you within your first 3(three) visits.**

****2. We will bill your health insurance carrier and have you assign payment to us for treatment in our office if you have provided us with the necessary information. Your co-payment is to be paid by you at the time of each visit.**

****3. If you receive a check from the insurance carrier for services rendered in our office, bring the check and any attached forms to this office immediately. We will need to have the documentation for what dates of services and what services were paid by the insurance carrier. You will not be permitted to make "payments" on an insurance check mailed to you. The account may be turned over to a collection agency if full payment is not made immediately.**

_____ 4. The verification provided by this office is not a guarantee that your insurance carrier will pay what has been stated. Your account is ultimately your responsibility. Any discrepancy between what is quoted on the insurance verification form and what is actually paid by your insurance carrier is your financial responsibility. You are more than welcome to dispute an adverse decision with your insurance company directly, but you will be responsible for making a payment in full to our office immediately.

****5. We will accept payment on your account in the form of CASH, ATM CARD, VISA, MASTERCARD, DISCOVER or CHECK.**

****6. If any insurance or personal information changes during the course of treatment, you are required to inform this office immediately. (Such as your insurance policy/plan updates or terminates, you have moved, or changed your phone number, etc.)**

_____7. There are a certain number of appointments available each day and often patients who are injured are unable to be scheduled the same day that they call. With this in mind, if you are unable to keep a scheduled appointment, we ask that you give us the courtesy of a phone call at least 24hrs prior to a missed appointment. Failure to do so will result in a $50.00 missed appointment fee.

****8. If you receive a bill, the payment is due upon receipt. All accounts with a balance over 45 days will be assessed a 1% late charge per month on the unpaid monthly balance. Payment plans can be arranged through the Billing department (410-517-2400). In the event that an account becomes assigned to a collection agency, the patient will pay 100% of collection agency fees, 100% of court costs, and 100% of attorney's fees.**

****** I HAVE READ, UNDERSTAND, AND ACCEPT THESE POLICIES IN FULL. *******
Please initial above and sign below.

PATIENT SIGNATURE_____ DATE_____

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Family Chiropractic

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File#_____

We ask that all Patients read and sign this document

DEALING WITH YOUR INSURANCE COMPANY

Insurance companies can be your best friend – or your worst enemy, particularly if you do not comply with their guidelines.

Since every insurance plan has its own special requirements, it is impossible for us to be familiar with each and every plan. Therefore, we must look to you, the patient, to assume the responsibility of knowing what your insurance coverage is. In the last analysis, the patient is **always responsible** for payment for any services rendered. We will, of course, be happy to complete all necessary forms and to submit to your insurance company claims for you and whatever documentation they require. However, this is done strictly as a service for you.

It should be pointed out that our contract for services is with you, the patient. We work for you; not for your insurance company. Reisterstown Family Chiropractic provides the best services that we are capable of providing and expect that payment for those services be made as promptly as possible. It is important, therefore, for you to become an informed consumer relative to your insurance coverage. As always **Co-pays and Co-insurances are due at the time of service.**

If your insurance company requires pre-certification or pre-authorization for any services, it is **your responsibility to obtain the authorization** and notify the doctor, as well as to provide Reisterstown Family Chiropractic with the proper forms and to monitor the number of approved visits.

Please contact your Primary Care Doctor's office if you have any questions about pre-certification. On most insurance cards there is a telephone number listed to call which can help you in understanding your coverage and exactly what needs to be obtained for certain services. Please feel free to discuss your concerns directly with Dr. Lipman or the designated staff member. If you have any questions regarding your billing statement, please contact the Coordinator of Operations, or your insurance company. We are here for you, and it is our pleasure to be of service to you.

_____ _____

(Patient's signature/ Guardian's signature) (Witness)

_____

(Date)

11710 Reisterstown Road, Suite 205 * Reisterstown, MD 21136
(410) 517-2400 * Fax (410) 630-5631 * www.familychirodoc.com

Reisterstown
Family Chiropractic

Dr. Howard M. Lipman
File #:_____

Assignment and Instruction for Direct Payment to Doctor by Private and/or Group Health Insurance

Patient:_____ ID#_____

Insured's Employer:_____ Grp/plan#:_____

I hereby instruct and direct that_____ insurance company make payment by check made out and mailed to:

REISTERSTOWN FAMILY CHIROPRACTIC
11710 REISTERSTOWN RD., SUITE 205
REISTERSTOWN, MD 21136

Or

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make the check payable to me and mail it as follows:

C/O REISTERSTOWN FAMILY CHIROPRACTIC
11710 REISTERSTOWN RD., SUITE 205
REISTERSTOWN, MD 21136

For the medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward my medical charges. **THIS IS AN IRREVOCABLE DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed nay indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said medical service charges over and above this insurance payment.

I also authorize the release of any information pertinent to my case to any insurance company, adjustor, or attorney involved in this case. I understand that this authorization shall not obligate REISTERSTOWN FAMILY CHIROPRACTIC / HOWARD M. LIPMAN, DC irrespective of whether any insurance carrier fails or refuses to make payment.

I understand that failure or refusal to pay the full amount of my account balance with this office may result in my account being referred for collection purposes. In this event, I will be responsible for all pre-judgment interest at 12% per annum, collection company fees, reasonable attorney's fees, court cost and related fees, and post-judgment interest at the legal rate.

A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ _____
Patient signature Witness

_____ _____
Signature of Policy Holder Date

Reisterstown
Family Chiropractic

Dr. Howard M. Lipman

File#: _____

Emergency Contact information:

Name: _____ Relation: _____
Phone Number: _____

Name: _____ Relation: _____
Phone Number: _____
Circle one of the following:
(Yes) I give permission to share my medical information with the above emergency contact(s).
(No) I do NOT give permission to share my medical information with the above-mentioned Emergency contact(s).

Missed Appointment Fee:

In our office your visit frequency is prescribed by Dr. Lipman. For best results we expect you to comply with your prescribed treatment program. We pre-schedule appointments for your convenience. This allows you to have the days and times during the week that work best for you. If you are scheduled and can NOT make it in, PLEASE BE CURTIOUS and call to reschedule your appointment. Missed appointments with NO call and NO show will result in a $50.00 Missed Appointment Fee.

☐ Please Check to receive text and/or email communications from our office.

The following will be used to secure payments for missed appointment fees and/or any other services received by you that are deemed a balance due to the office.
As a courtesy, we will call you and let you know we will charge the amount due by the end of that day, if we do not hear from you.

Required….
Credit Card number _____ Visa Master Card Discover
Exp. Date: _____ Security Code/ CVV: _____
Billing Zip Code: _____

I approve for the above card to be charged for balances due & if I fail to call and reschedule my appointment

Sign: _____ Date: _____
*By law we MUST protect this information, and NO one will have access to your personal CC information.