Carey Chiropractic, P.A.
Dr. Marisa Carey
103 Poplar Street • P.O. Box A
Fruitland, MD 21826
410-546-2225

Patient Name: _____

Please fill in if you or any blood relative (mother, father, brothers, sisters, uncles, etc.) has had:

Arthritis _____
Cancer _____
Diabetes _____
Heart disease _____
Hypertension _____
Epilepsy _____
Tuberculosis _____
Mental Illness _____
Stroke _____
Other _____

Do you now **have or** have you **had within the past year**:

NMS
___ Headache
___ Anxiety
___ Depression
___ Numbness
___ Tingling
___ Sleeplessness
___ Neck/Arm pains
___ Shoulder pains
___ Back pains
___ Sciatica
___ Osteoporosis

GU
___ Kidney Stones
___ Frequent urination
___ Urgency
___ Painful urination
___ Discolored urine
___ Prostate pain
___ Sexual transmitted disease
___ Hernia
___ Abnormal menses
___ Lumps on breast
___ Other

GI
___ Weight loss/gain
___ Excessive hunger
___ Excessive Thirst
___ Vomiting
___ Abdominal Pain
___ Diarrhea
___ Constipation
___ Hemorrhoids
___ Gall stones
___ Belching
___ Hiatal Hernia
___ Other

CV
___ Chest Pain
___ Short breath
___ Cough
___ Heart Problems
___ Hypertension
___ Discoloration of skin
___ Varicosities
___ Stenosis
___ Diabetes
___ Neuropathy
___ Autoimmune Disease
___ Other

Chief complaint today _____

Do you drink alcohol? If so, how much in a week? _____

Are you a smoker or have been in the past, if so, list how many cigarettes a day and years of use: _____

Do you or have you used recreational drugs, if so, list them and duration of use: _____

Are you or have you been a victim of domestic abuse? _____

Was this condition caused by a motor vehicle accident? _____

Is this condition in any way work related? _____

Who may we thank for your referral? _____

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Date: _____

Please Print Your Information

Patient Name: _____

Gender: ☐ Female ☐ Male ☐ Other

Social Security #: _____

Drivers License #: _____

Date of Birth: _____

Patient Address: _____

_____

Cell Phone #: _____

Home Phone #: _____

Hobbies: _____

Employer Name/Address: _____

_____

_____

Employer Phone #: _____

Occupation: _____

Your Email: _____

Spouse Name: _____

Spouse Employer: _____

Spouse Phone #: _____

Name of closest friend or relative whom we may call in case of emergency: _____

Emergency Phone #: _____

_____

_____

Emergency Contact's Address: _____

Medical Insurance: _____

Do you have Medicare? Yes ☐ No ☐

Insurance Address: _____

_____

Insurance Phone #: _____

Please list any accidents, surgery, or major illness: _____

_____

_____

_____

Please list any and all medications now taking: _____

_____

_____

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Patient Name: _____

HISTORY

OFFICE USE ONLY

Please describe your chief complaint:

1. Date of injury: _____

2. Ever hurt it before? If so give diagnosis & Dr.'s name

_____

_____

3. What makes it better? _____

4. What makes it worse? _____

5. Describe the pain (dull, sharp, achy, etc.):_____

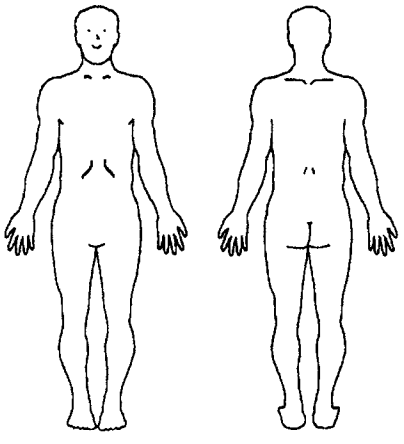
6. Is the pain constant or on and off?_____

7. Is there a time of day the pain is worse or better?

_____

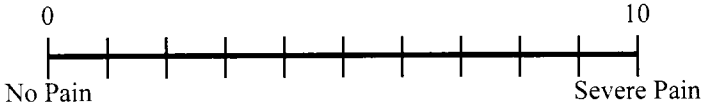
_____

Please use the diagram below to **drawn in pain** areas.



Front Back

Also, please fill in the pain scale:



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Patient Name: _____

Age: _____ **Date:** _____

Vitals: Weight _____ Height _____ Temp. _____ Pulse _____ BP _____ Pulse O2 _____

Posture _____
Head tilt _____
High Shoulder _____
High iliac crest _____
Scoliosis _____

A-P Curves _____
Cer. _____
Th. _____
Lumbar _____
_____

Shoulder/Wrist/Elbow
_____
_____
_____
_____

Cranial Nerves
REFLEXES _____
MOTOR _____
SENSORY _____
OTHER _____

Lumbar Rom		**R/L**
FLEX.	(90)	__/__
EXT.	(30)	__/__
LAT. FLEX.	(30)	__/__
ROT.	(30)	__/__

Cervical Rom		**R/L**
FLEX.	(40)	__/__
EXT.	(40)	__/__
LAT. FLEX.	(40)	__/__
ROT.	(80)	__/__

NEURO:	**C5**	**C6**	**C7**	**C8**	**T1**
DTR	___	___	___	___	___
MOTOR	___	___	___	___	___
SENSORY	___	___	___	___	___
OTHER	___	___	___	___	___

NEURO:	**L1**	**L2**	**L3**	**L4**	**L5**	**S1**	**S2**
DTR	___	___	___	___	___	___	___
MOTOR	___	___	___	___	___	___	___
SENSORY	___	___	___	___	___	___	___
OTHER	___	___	___	___	___	___	___

ORTHO:
BECHTEREW _____
KEMPS _____
SLR _____
FABERE _____
ADDSON _____
COZENS _____

MILLS _____
BOWSTRING _____
YEOMANS _____
FAJERSTEIN _____
KLEINS _____
MAN COMPR C _____

ORTHO:
MAN COMPR T _____
MAN COMPR L _____
MAN COMPR SI R ___ L ___
OTHER _____

CHEST/HEART
I _____
P _____
A _____
P _____

HIP/KNEE/FOOT/ANKLE
_____
_____
_____
_____

ABDOMEN
I _____
P _____
A _____
P _____

LYMPH NODES
UPPER EXTR _____
LOWER EXTR _____
PULSES UPPER _____
PULSES LOWER _____

Muscle Palpation: _____

Motion Palpation: _____

Impression DX: _____

_____

TX: _____

_____

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IRREVOCABLE ASSIGNMENT, LIEN AND AUTHORIZATION INSURANCE BENEFITS & ATTORNEY

To Whom It May Concern:

I hereby authorize and direct any insurance company and/or my attorney, to pay directly to Carey Chiropractic such sums as may be due and owing this office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, and withhold such sums from any disability benefits, medical payment benefits, no—fault benefits, health and accident benefits. Worker's Compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment or verdict which may be paid to me, my heirs, personal representatives, beneficiaries or attorneys on my behalf, as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the office services provided.

In the event the insurance company is obligated to make payments to me upon the charges made by this office for their service refuses to make such payments, upon demand by me of this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor against such company and authorize the office to prosecute said cause of action either in my name or in the offices name and further I authorize this office to compromise, settle or otherwise resolve such claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amounts due this office for their services, I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the office to await payments and they may demand payments from me immediately upon rendering services at their option. I also understand that if settlement does not cover the entire amount for services provided I am still responsible for the remainder. I do hereby waive any applicable statute of limitations on the collection of my account with this office. I further understand and agree, that if my account has a balance over thirty (30) days, a finance charge of 1.5% accrued monthly will be added to my account. Further, I acknowledge that if my account becomes delinquent (over sixty days) and is referred to collections, the undersigned agrees to any and all additional costs incurred in collecting this debt. This includes but is not limited to attorney's fees up to thirty—three and one—third percent (33.3%) and all court costs expended in connection with the collection of my account.

I authorize the office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under the Assignment, Lien and Authorization. I agree to that the above mentioned office be given Power of Attorney to endorse/sign my name to any and all checks for payment of my doctor bill.

Dated:_____

Signed:_____

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CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form, you are granting consent to CAREY CHIROPRACTIC, P.A. to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting this office. You have a right to request that we restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

_____
(print name)

_____ _____
(signature) (date)

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Patient Name: _____

GROUP INSURANCE POLICY

This office accepts assignment of benefits from most insurance companies. Verification of your insurance coverage must be obtained before assignment will be allowed.

It is important to know, however, that ***your group plan is a relationship between you and your insurance company***. The ultimate responsibility for payment of services is with you. Until coverage has been verified, you will be responsible for payment of services rendered.

Generally most insurance plans have deductible clauses. Therefore, any deductible portion of the bill is your responsibility as well as any co-insurance (that portion not covered by the plan). We ask that co-insurance be paid each visit, unless other arrangements are made.

Your carrier will be billed on a regular billing cycle. If the carrier fails to pay within a reasonable period of time (within 45 days of billing), we will notify you.

Failure for a claim to be paid within 60 days of billing may result in your personal liability for this bill.

We will not submit charges for missed appointments. This is your personal responsibility with this office.

At the time that all insurance payments have been recieved, if there is an overpayment we will either issue a check or apply that credit to your account. We will be reconciling your account as each payment is made. If there is a balance owed, payment can be made by cash, check Mastercard or VISA.

☐ ***I have read and understand this policy.***

_____ _____

(patient or responsible party signature) (date)

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Patient Name: _____

VOLUNTARY WAIVER OF HMO BENEFITS

Signing this document will alter your legal rights under Maryland law.
Please read carefully and do not sign unless you understand the document.

I, _____ (patient name) am seeking

medical treatment from _____ ("My Chiropractor").

CHECK ONE

☐ I am not a member of a Health Maintenance Organization ("HMO") and will be responsible for the payment of any amounts owed to My Chiropractor for services provided.

OR

☐ I am a member of an HMO but I have been informed that My Chiropractor is not a participating chiropractor with that HMO and that if My Chiropractor provides services to me, I will be billed at my chiropractor's usual rate and I, instead of my HMO, will be responsible for full payment of that bill.

I understand that if, instead of receiving treatment from My Chiropractor, I had elected to obtain treatment from a health care provider participating in my HMO and the HMO determined that the service was covered under my benefit plan, I would be entitled to have this service reimbursed as set forth in that plan;

Therefore, this means that:

1. I will be solely responsible for My Chiropractor's charges;

2. My Chiropractor will not seek payment from my HMO.

_____ _____

(patient name) (date)