ADVANCED CARE CHIROPRACTIC --- REGISTRATION

Date_____ Home Phone _____ Cell _____

Patient _____ _____
Last First Initial e-mail address

Street Address_____

City_____ State _____ Zip _____

Sex ☐M ☐F Age _____ Birth date_____ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Social Security # _____ Insured's Name _____
(if other than self) Last First Initial

Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other Condition Related to: ☐Illness ☐Employment ☐Auto ☐Other

PLEASE GIVE INSURANCE CARD(S) TO SECRETARY

YOUR EMPLOYER	Company Name_____ Occupation_____ Address _____ Phone _____ City _____ State _____ Zip _____
YOUR SPOUSE OR INSURED PARENT/ GUARDIAN	Name_____ Cell_____ Birth date _____ Social Security # _____ Employer Name _____ Occupation _____ Address _____ Phone _____ City_____ State _____ Zip _____
MEDICAL & LEGAL INFORMATION **PLEASE GIVE INSURANCE CARDS TO SECRETARY**	**Referred by** _____ Family Physician _____ Address _____ Phone_____ Known Medical Problems _____ _____ Person to contact in emergency (Name & Phone #) _____ Pregnant ☐Yes ☐No Pacemaker ☐Yes ☐No _____ Is this due to an auto accident? ☐Yes ☐No If yes, DATE OF ACCIDENT _____ Auto Insurance Company_____ Claim #_____ Address _____ Adjuster _____ _____ Phone # _____
PATIENT AGREEMENT	ASSIGNMENT AND RELEASE I, the undersigned, have insurance coverage with _____ and assign directly to Dr. Kevin Fielden all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. _____ _____ Signature of Insured/Guardian Date

Name_____

Height_____ **Weight**_____

Have you ever received Chiropractic Care? (Yes / No) If yes, when and who?_____

1. **Chief Complaint:** _____

Complaint began (**approx. date**)_____gradually / suddenly. Is pain getting: Better / Worse / Staying the Same

Describe how it began:_____

How frequent is complaint present, how long does it last?_____

What activities make the complaint better?_____

What activities make the complaint worse?_____

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint?

_____

3. Past Health History: Previous serious illnesses / injury / or trauma you've had in your life?_____

_____

Have you ever broken any bones? Which?_____

A. **Medications:** (additional space on back of this page, if needed)

Medications	Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____

B. **Allergies**:_____

C. **Surgeries:** Date: (or approx. year) Type of Surgery (use back page, if needed)

_____	_____
_____	_____
_____	_____

D. **Females/Pregnancies and outcomes**: Pregnancies/Year of Delivery (example: boy, 1980, natural, or C-Section)

_____	_____
_____	_____

What was the date of the beginning of your last menstrual period?_____

4. Family Health History: Associated health problems of immediate relatives:_____

_____

Deaths in immediate family: Cause of parents or siblings death Age of death

_____	_____
_____	_____

5. **Social and Occupational History:** Job description:_____

Work Schedule:_____ Recreational Activities:_____

Level of exercise, describe:_____

Alcohol_____ Tobacco (packs per day)_____ Are you on a diet program?_____

Other:_____

PAIN DISABILITY INDEX QUESTIONNAIRE

Name_____ Date_____

Primary Complaint: _____

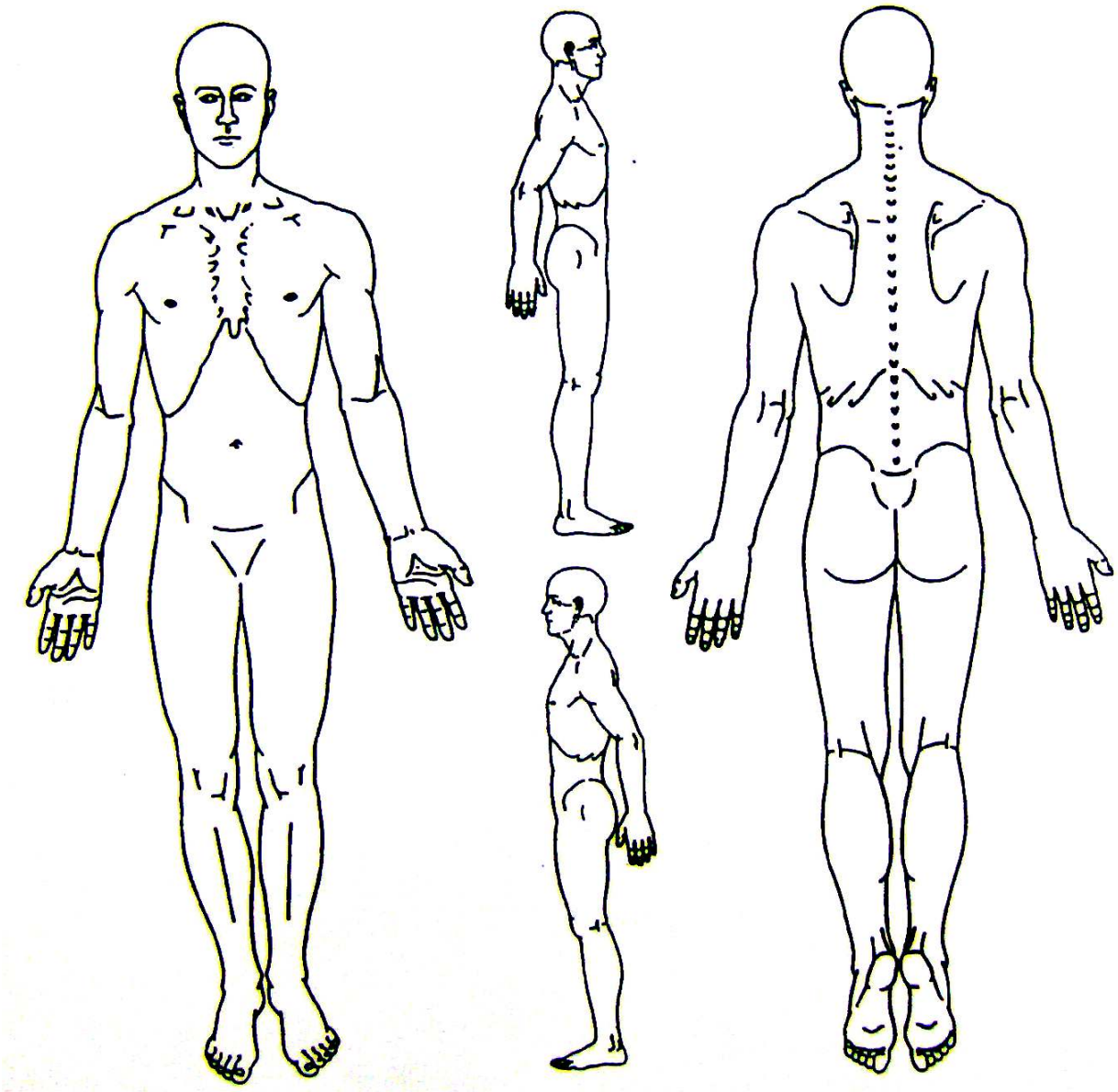
How long have you had this pain? _____ Pain Intensity (0=none, 10= worst pain ever)_____
Is this your first episode of pain? Yes____ No____
How often do you experience your symptoms? _____Constantly (76-100% of the day), _____Frequently (51-75% of the day),
_____Occasionally (26-50% of the day), _____Intermittently (0-25% of the day)

Secondary Complaint:_____

How long have you had this pain? _____ Pain Intensity (0=none, 10= worst pain ever)_____
Is this your first episode of pain? Yes____ No____
How often do you experience your symptoms? _____Constantly (76-100% of the day), _____Frequently (51-75% of the day),
_____Occasionally (26-50% of the day), _____Intermittently (0-25% of the day)

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR COMPLAINT

KEY	A=ACHE	B=BURNING	N=NUMBNESS
	P=PINS & NEEDLES	S=STABBING	O=OTHER_____



Back Index(complete if you are being evaluated for back pain)

Patient Name_____Date _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

A - Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

B - Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

C - Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

D - Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

E - Walking

⓪ I have no pain while walking.
① I have pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

F - Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

G - Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

H - Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate form of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

I - Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

J - Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Back Index

For Dr. Notes:
GOALS: _____ _____
_____ _____

Neck Index (complete if you are being evaluated for neck pain)

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

A - Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

B - Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

C - Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

D - Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

E - Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

F - Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

G - Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

H - Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

I - Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

J - Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

For Dr. Notes:
GOALS: _____ _____
_____ _____

Neck Index ☐

KEVIN D. FIELDEN, DC

3043 BOONE'S CREEK RD., SUITE 107
JOHNSON CITY, TN 37615
423-929-2225 FAX 423-232-1379

FINANCIAL AGREEMENT

In consideration of Dr. Kevin D. Fielden (hereinafter, "Fielden") undertaking to treat the undersigned patient (hereinafter, "Patient"), Patient agrees to the following:

Unless otherwise agreed, charges for treatment are due at the time service is provided. As a courtesy to the Patient, our office will submit patient's bills to the appropriate insurance companies, agencies, and/or attorneys. However, Patient is responsible for payment of deductibles and any portions not paid by their insurance**. Patient will be personally responsible for payment of his/her account regardless of any settlement or benefits of any type Patient may or may not receive.** In the event any insurance company makes payment directly to Patient, Patient agrees to pay his/her account in full within 72 hours of such payment. If Patient chooses to suspend or terminate his/her care, the balance of patient's account shall be immediately due and payable. A late payment charge of 1.5% per month may be applied to all past due balances. Additionally, in the event Patient's account is placed with a third party collector, the Patient or the Patient's legal guardian (if patient is a minor) shall be responsible for all collection charges, which may be up to 50% of the current total balance due, as well as any attorney fees, court costs, and all other costs incurred during collections.

_____ _____

Patient Signature Date

MEDICARE AND SECONDARY INSURANCE INFORMATION FORM

Effective January 1, 1994

1. Medicare states that since we are a participating physician we must accept assignment.
2. Therefore, Medicare will be billed.
3. In the event that Medicare does not approve payment, you will be billed for the total amount charged.

EXPLANATION OF INSURANCE COVERAGE

According to the guidelines of the Medicare Administration, Federal Medicare will reimburse 80% of the allowed amount of Chiropractic treatment charges (manipulation of the spine) after the yearly deductible of $147.00 has been met. Also, according to the Medicare Bulletin dated December 1985, Medicare, upon review, may limit the amount of chiropractic treatment for certain conditions. If, upon Medicare's review further treatment charges are not considered medically necessary, you will be personally responsible for these charges. We will gladly file your secondary insurance but ask that you understand that their payment will only be on the allowed amount from the Medicare Administration. The fees for additional services that may be necessary to treat your condition will be explained to you before any services are performed. Payment for any non-covered service will be due on a daily basis. If these payment arrangements become inconvenient for you, please see our office manager so other arrangements can be made for you.

Our office will complete the necessary forms for Medicare reimbursement at no additional charge to you. When you receive a statement of charges from our office, DO NOT submit it to Medicare, it is for your own records. I HAVE READ AND AGREE TO THE ABOVE.

_____ _____

Patient's Signature Date

AUTHORIZATION FOR RELEASE OF X-RAYS AND/OR RECORDS

I hereby request that you release my medical records and/or X-rays to:

Dr. Kevin D. Fielden, DC
3043 Boone's Creek Rd., Suite 107
Johnson City, TN 37615
423-929-2225 FAX 232-1379

Patient/Guardian Signature_____ Date_____

DR.KEVIN D. FIELDEN, D.C.
Advanced Care Chiropractic and Rehab
3043 BOONE'S CREEK RD., SUITE 107
JOHNSON CITY, TN 37615
423-929-2226 FAX 423-232-1379

IMPORTANT NOTICE TO ALL INSURANCE PATIENTS

We will be happy to call your insurance company to inquire about your chiropractic services coverage. Please be aware when we explain your coverage to you that we are only repeating what your insurance company has told us. Occasionally an insurance company will tell us incorrect information regarding coverage and our office cannot be responsible for incorrect information given to us. If your insurance company denies coverage or reimburses a different amount than expected, the patient is still responsible for the full amount due. Your health insurance is a contract between you and your insurance company. We encourage you to call to verify your chiropractic services coverage as well or consult your insurance policy handbook for benefit information.

I have read and understand the above:_____
Signature