Lykens Chiropractic
CELEBRATING 25 YEARS

540-667-7388
650 Cedar Creek Grade #207
Winchester, VA 22601
www.LykensChiropractic.com

Appt: Patient #:

PATIENT INFORMATION

Name_____ Date _____ Referred by_____
First MI Last

Address_____ City/State/Zip_____

Phone # _____ Cell # _____ Email Address _____

Social Security #_____ Birth Date _____ Gender: Male___ Female___

Weight _____ Height ____' ____" Preferred Language _____

CMS requires providers to report both race and ethnicity:

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Marital Status: married___ divorced___ single___ separated___ widowed___ Number of children_____

Current Employer_____ Occupation_____

Employer Address (if known) _____ Work Phone # _____

EMERGENCY CONTACT/PARENT INFORMATION

Name _____ Relationship _____ Phone # _____

FEMALE PATIENTS RECEIVING X-RAYS

Here at LYKENS CHIROPRACTIC, Inc., we want to ensure that each and every patient receives the safest care possible. If by chance you are pregnant, it is important that we protect you from any unnecessary radiation that could affect the development of an unborn child in uterus.

Is there a chance that you may be pregnant at this time? ___YES ___NO Date of last menses_____

By signing your name below, you deny pregnancy at this time and give permission to proceed with your X-ray if needed.

*Signature*_____ *Date*_____

PURPOSE FOR TODAY'S APPOINTMENT
(Please X all that apply)

Maintaining a healthy lifestyle_____ Enhancing athletic performance_____ Prevention of illnesses_____

Relief for a specific injury or condition_____ Improving your overall health without drugs or surgery_____

Please list below the main complaints you have in order of their importance.

1. _____ How long? _____
2. _____ How long? _____
3. _____ How long? _____
4. _____ How long? _____

What caused today's problem? *(give date if known)* _____
Have you experienced this problem in the past? ___Yes ___No If so, when? _____
Describe your pain or discomfort *(dull, sharp, burning, tingling, pins & needles, stabbing, numb, etc)*

_____
Does this problem stay in one area or travel somewhere else? _____
Are you experiencing any restrictions in your range of motion? If yes, which joints? _____
What makes it better? *(sitting, standing, walking, lying down, etc)*_____
What makes it worse? _____
Have you seen anyone else for this condition and when? _____
Have you taken anything for this condition since it began or tried something to help your problem? (i*f yes, explain)*

_____
Have you had an MRI or any other imaging of the spine done? YES/NO If yes, when and where

_____
How has this affected your daily activities? _____

HEALTH CARE HISTORY

Do you regularly consult any of the following care providers? (check all that apply)
___Medical Physician ___Naturopath ___Acupuncturist ___Homeopath ___Psychotherapist ___Dentist
Name and reason why: _____
Date of last medical examination_____ Were there any complications? _____
Have you been to a Chiropractor before? YES / NO Date of last adjustment_____ Chiropractor_____
Reason for previous chiropractic care_____
How often did you go? ___Regular monthly check-ups ___Bi-weekly ___Weekly ___Only when needed
Why did you discontinue care?_____
Are you or have been treated by a Physical Therapist? YES/NO How often are you being seen? _____
Have you ever had a professional massage before? YES/NO If yes, when was your last visit: _____
Do you have a pressure preference with massage? ___ Light Pressure ___ Medium Pressure ___ Deep Pressure
Are you sensitive to fragrances, perfumes, or nut oils? YES/NO If yes, please explain _____

PAST HISTORY

Have you had any accidents related to any of the following? (check all that apply)
___Automobile ___Motorcycle ___Bicycle ___Sports ___Playground ___Abuse
If yes, please explain how and dates: _____
Have you ever injured your spine (head, neck, rib/chest area, back, pelvis, or hips)? ___Yes ___No
If yes, please explain how and dates: _____
Have you ever been hospitalized? ___Yes ___No If yes, please explain why and for how long:

_____
List any other injuries or accidents & dates_____
List any surgeries & dates_____

Do you have a family history of ___arthritis ___cancer ___diabetes ___heart disease ___scoliosis?
Do you or have you ever used tobacco products? YES / NO If yes; former smoker____ current smoker____
#___per day If yes, what year started _____ and/or what year stopped _____
Have you been exposed to any of the following on a regular basis, (past or present)?
___Toxic chemicals ___Drugs (prescribed or not) ___Second hand smoke ___Other
If yes, please explain:

_____

List anything that you have been **diagnosed** with (past or current)

_____

Prescription and non-prescription medication may cause various side effects, hide the severity of health problems, and hinder the body's ability to heal. Are you currently taking any medications? (Include regularly used over the counter medications)

Medication Name	Treating	Dosage and Frequency

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

What vitamins or other nutritional supplements do you take?

_____

How often do you consume the following? Coffee/caffeine #___ per week Alcohol #___ per week Diet soda #__per week
Do you exercise? YES / NO How often and what activities? _____
How many servings of **RAW** fruits and vegetables do you consume per day? _____
Do you get sufficient sleep at night? YES/NO

_____

How much water do you drink throughout the day?

_____

What are your health goals?

Immediate:

_____

Short Term (Something You Have To Do):

_____

Long Term (Something You Want To Do):

_____

PAST & PRESENT CONDITIONS

(Please X all that apply)

___Neck pain (right/left)
___Headaches
___Numbness in arms, hands, fingers
___Ear Infections
___Frequent Colds or Flu
___Allergies/Sinus Problems
___Loss of Taste or Smell
___Dizziness
___Blurred or Doubled Vision
___Convulsion/Epilepsy
___Stroke, Date _____
___Pass Out
___Trouble Concentrating
___Trouble Sleeping
___Nervousness/Anxiety
___Mental/Emotional Disorders:_____
___ Jaw Pain/Clenching

___Asthma/Difficulty Breathing
___Shoulder Pain (right/left)
___Chest Pain
___Heart Problems
___High/Low Blood Pressure
___Digestive Problems/Heartburn
___Ulcers
___Gall Bladder Problems
___Mid-Back Pain/Stiffness
___Hip Pain (right/left)
___Numbness in legs, feet, toes
___Knee Pain (right/left)
___Kidney Troubles
___Frequent/Difficulty Urination
___Diarrhea/Constipation
___Colon Trouble
___Hemorrhoids

___Excessive Gas
___Liver Problems
___PMS/Menstrual Problems
___Impotence
___Prostate Problems
___Hernias
___Blood Clots
___Varicose Veins
___Arthritis/Tendonitis
___Swollen/Painful Joints
___Joint Replacements: _____
___Fractured Bones: _____
___Muscle Spasms
___Fibromyalgia
___Cancer/Tumors
___Abnormal skin condition
___Contagious or Infectious Diseases

QUALITY OF LIFE

How do you grade your physical health?	___Good	___Fair	___Poor
How do you grade your emotional/mental health?	___Good	___Fair	___Poor
How do you rate your overall "quality of life"?	___Good	___Fair	___Poor
How do your rate your current diet/nutritional state?	___Good	___Fair	___Poor
How would you rate your level of negative stress?	___Good	___Fair	___Poor

Patient Signature:_____ Date: _____

LYKENS CHIROPRACTIC, INC. FINANCIAL POLICIES

Thank you for choosing Lykens Chiropractic as your health care provider. We are committed to the success of your treatment. The following are statements of our Policies, which we require you read and sign prior to any treatment. All patients must complete our Patient Information, Health Information, Policy and Coverage forms before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. WE ACCEPT CASH, CHECKS, CREDIT AND DEBIT CARDS. RETURNED CHECK FEE: THERE WILL BE A $20 FEE PER RETURNED CHECK IF YOUR CHECK IS NOT HONORED BY THE BANK UPON FIRST DEPOSIT. WE OFFER AN EXTENDED PAYMENT PLAN WHERE NECESSARY AND WHERE THIS FINANCIAL AGREEMENT IS SIGNED.

REGARDING INSURANCE

We do not participate with any insurance networks. Your commercial insurance plan is a contract between you and your insurance company. Lykens Chiropractic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for services you receive from Lykens Chiropractic is your responsibility whether your insurance company pays or not. _____ (Initials).

NON-COVERED SERVICES

For Medicare clients, your care may involve services that are not covered under your benefits. **Non-covered services, including maintenance, palliative and preventive physical medicine and/or chiropractic services will not be billed to your insurance company as these services are never covered.** You have the right to deny receipt of these services. If you

elect to receive a non-covered service that is recommended or necessary to your care, you will be fully responsible for payment of these services and consistent with the provision above, you agree that these services will not be reported to your insurance carrier. Lykens Chiropractic is not obligated to report non-covered services on your behalf. _____ (Initials).

MISSED APPOINTMENT/LATE NOTICE

Please help us serve you better by keeping scheduled appointments. Our ability to assist you with meeting your health goals is in significant part based on your commitment to your treatment program. Please note that if you are self-billing, insurance will not cover the cost of missed appointment fees. Our office requires 24-hour notice to reschedule an appointment. For a missed chiropractic appointment, the fee will be $52. For a massage therapy appointment, you will be charged the full amount of the scheduled session. _____ (Initials)

PERSONAL INJURY/WORKERS' COMPENSATION

Lykens Chiropractic, Inc. does not accept New Patients as personal injury/ motor vehicle accident or workers' compensation cases. In the event that you need to file a personal injury/ MVA or W.C. case as an established patient, you will be responsible for payment at the time of service. As a courtesy we will provide copies of records upon request _____ (Initials).

FINANCIAL ARRANGEMENTS

Where necessary based on your financial circumstances, we will permit you to make payment arrangements. Strict adherence to the financial arrangements you make is required. You must relay any changes you may require to your previously agreed financial arrangements to our financial department immediately. Past due balances that cannot be handled in house will be referred to outside collection agencies or to litigation for collection. Where this is necessary, you agree to be additionally responsible for any costs and attorneys' fees related to the collection of unpaid amounts.

By providing the information below, I, the undersigned, have read and understand and agree to the above policies and further agree to be responsible for any services I receive. In the event that other payment arrangements are not made and agreed to by Lykens Chiropractic, they are authorized to charge any amount due to the credit card on file. The undersigned further represents possession of the authority to grant such an authorization related to the billing of amounts due to Lykens Chiropractic to the credit card on file. The undersigned understands that the authorization to bill the credit card on file for incurred charges may be terminated, but in such event the undersigned agrees to provide Lykens Chiropractic with reasonable notice of termination. "Reasonable notice" is defined as written notice at least 30 days in advance of termination of the authorization. Should there be any change relating to the credit card information on file, the undersigned agrees to provide updated information to Lykens Chiropractic prior to the end of the month in which such changes occur or upon demand. The undersigned further understands that termination of the authorization to bill unpaid fees for services received to the credit card on file does not alleviate the undersigned patient from the responsibility to pay any amount that became due prior to or after notice of termination is provided.

I have read and agree to these clinic policies and authorize payment to Lykens Chiropractic and further authorize Lykens Chiropractic to bill my credit card as detailed above or where no credit card information is provided, agree to complete a financial agreement related to payment for services received but not paid for in full.

_____ _____

Signature of Patient or Responsible Party/Guardian Date

_____ _____

Signature of Staff Witness Date

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES – RELEASE OF INFORMATION

Lykens Chiropractic is concerned about the privacy of your individually identifiable health information and has enacted policies and procedures to protect your privacy as required by the Health Insurance Portability and Accountability Act of 1996. A notice of this clinic's privacy practices is posted in the clinic or can be obtained from a staff member. Your acknowledgement of "receipt" of the Lykens Chiropractic Notice of Privacy Practices or our good faith effort to obtain your acknowledgement permits Lykens Chiropractic to release your protected health information for purposes of treatment, payment, or healthcare operations only.

I acknowledge that I have received the Notice of Privacy Practices for protected health information.

_____ _____

Signature of Patient or Responsible Party/Guardian Date

NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS (NEMB)

There are items and services for which Medicare will not pay and which are not required to be billed to Medicare on your behalf.

- Medicare does not pay for all of your health care costs. Medicare only pays for covered benefits. Some items and services are not Medicare benefits and Medicare will not pay for them. When you receive an item or service that is not a Medicare benefit, you are responsible to pay for it, personally or through any other insurance that you may have. The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself.
- Before you make a decision, you should read this entire notice carefully.
- Ask us to explain, if you don't understand why Medicare won't pay.
- Ask us how much these items or services will cost you.
- **We are not required to submit claims for non-covered services and <u>will not do so</u>.**

Medicare will not pay for:

☑ The following services when performed by a licensed Doctor of Chiropractic:

1. Evaluation and Management Services to include examinations necessary to prepare treatment plans required to justify the medical necessity of potentially covered services such as manipulation
2. X-Rays/MRI/CT, Electrodiagnostic Testing, Physical Performance and Range of Motion Testing when ordered or performed by a Chiropractor
3. Physical Medicine Modalities such as the application of hot/cold packs, electric stimulation, ultrasound, mechanical traction or hydrotherapy.
4. Physical Medicine Procedures such as manual therapy, which may include non-manipulative adjusting techniques, therapeutic exercises and/or therapeutic activities
5. DME items when prescribed by a Doctor of Chiropractic.

☐ Maintenance manipulation.

CMS defines maintenance manipulation as follows:
Maintenance therapy includes services that seek to **<u>prevent disease</u>**, **<u>promote health</u>** and prolong and enhance the quality of life, or **<u>maintain or prevent deterioration of a chronic condition</u>**. When **<u>further clinical improvement cannot reasonably be expected from continuous ongoing care</u>**, and the chiropractic treatment becomes **<u>supportive rather than corrective in nature</u>**, the treatment is then considered maintenance therapy. [emphasis added]

☑ **1. Because it does not meet the definition of any Medicare benefit.**

☑ **2. Because of the following exclusion from Medicare benefits***

☐ Non Medically Necessary Services
☑ Services not covered when performed by DC
☐ Orthopedic shoes and foot supports (orthotics).

☐ Other _____.

* **This is only a general summary of exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.**

By my signature below, I acknowledge and understand that non-covered services need not be billed on my behalf to Medicare on the basis that such services would not be compensable under the Medicare program. I further understand and agree that the provision of non-covered services **is conditioned on my agreement that these services are not to be billed to Medicare. Further, I agree to not seek reimbursement for such services from Medicare through direct billing to my Medicare Administrative Contractor.**

_____ _____

Signature of Patient or Responsible Party/Guardian Date