# WELCOME TO
# CROSSROADS WELLNESS & REHAB

Date:_____ Name:_____ Home Phone:(____)_____

E-Mail:_____ Cell Phone: (____)_____

Address:_____ City:_____ State:_____ Zip:_____

Date of Birth:___/___/_____ Age:_____ SSN:_____ DL:_____ State:_____

Occupation:_____ Employer:_____Work Phone: (____)_____

Occupation Address:_____
Street City State Zip

[ ] Single [ ] Married [ ] Other Spouses Name:_____

Nearest Relative Not Living With You:_____

Relationship:_____ Phone: (____)_____

Who (or what source) referred you? _____

## Insurance Information

Name of Health Insurance Company:_____

Insurance Holder's Name:_____ Date of Birth:__/___/____. SSN:_____

Insured's Employer_____

Relationship to You: [ ] Self [ ] Spouse [ ] Mother [ ] Father

Is this complaint due to a work related or auto accident: YES / NO

Any time lost from work due to this illness or accident: YES / NO From:_____ To:_____

I authorize that any healthcare (including lab reports, test results, etc.) and/or billing related information may be left on:

_____ on my home answering service.
_____ on my work answering service.
_____ with: (full name of person: _____.)

*Signing below verifies your consent to the rendering of care including treatment and performance of diagnostic procedures.*

Patient Signature:_____ Date:_____

If Minor, Parent/Guardian Signature of Consent:_____ Date:_____

Office Witness:_____ Date:_____ Acct:_____

# CASE HISTORY FORM

**CONSTITUTIONAL**

- ☐ DENY ALL
- ☐ CHILLS
- ☐ FAINTING
- ☐ FATIGUE
- ☐ FEVER
- ☐ NIGHT SWEATS
- ☐ WEAKNESS
- ☐ WEIGHT GAIN
- ☐ WEIGHT LOSS

**INTEGUMENTARY**

- ☐ DENY ALL
- ☐ ECZEMA
- ☐ HAIR GROWTH
- ☐ HAIR LOSS
- ☐ HIVES
- ☐ ITCHING
- ☐ PARESTHESIA
- ☐ RASH
- ☐ SKIN LESIONS

**PSYCHIATRIC**

- ☐ DENY ALL
- ☐ AGITATION
- ☐ ANXIETY
- ☐ APPETITE CHANGES
- ☐ BEHAVIORAL CHANGES
- ☐ BIPOLAR DISORDER
- ☐ CONFUSION
- ☐ DEPRESSION
- ☐ HOMICIDAL INDICATION
- ☐ INSOMNIA
- ☐ MEMORY LOSS
- ☐ SUBSTANCE ABUSE
- ☐ SUICIDAL INDICATION

**EYES**

- ☐ DENY ALL
- ☐ BLURRED VISION
- ☐ CATARACTS
- ☐ CHANGE IN VISION
- ☐ DOUBLE VISION
- ☐ DRY EYES
- ☐ GLAUCOMA
- ☐ SENSITIVITY TO LIGHT
- ☐ TEARING

**GASTROINTESTINAL**

- ☐ DENY ALL
- ☐ ABDOMINAL PAIN
- ☐ BLACK, TARRY STOOLS
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ HEARTBURN
- ☐ HEMORRHOIDS
- ☐ INDIGESTION
- ☐ NAUSEA
- ☐ RECTAL BLEEDING
- ☐ VOMITING

**ALLERGIC/IMMUNOLOGIC**

- ☐ DENY ALL
- ☐ HISTORY OF ANAPHYLAXIS
- ☐ ITCHY EYES
- ☐ SNEEZING

**HEMATOLOGIC/LYMPHATIC**

- ☐ DENY ALL
- ☐ ANEMIA
- ☐ BLEEDING
- ☐ BLOOD CLOTTING
- ☐ BLOOD TRANSFUSIONS
- ☐ BRUISE EASILY
- ☐ LYMPH NODE SWELLING

**MUSCULOSKELETAL**

- ☐ DENY ALL
- ☐ ARTHRITIS
- ☐ NECK PAIN
- ☐ DECREASED MOTION
- ☐ GOUT
- ☐ INJURIES
- ☐ JOINT PAIN
- ☐ BACK PAIN
- ☐ MUSCLE CRAMPS
- ☐ MUSCLE PAIN
- ☐ MUSCLE WEAKNESS
- ☐ SWELLING

**CARDIOVASCULAR**

- ☐ DENY ALL
- ☐ ANGINA
- ☐ CHEST PAIN
- ☐ HEART MURMUR
- ☐ HEART PROBLEMS
- ☐ HIGH BLOOD PRESSURE
- ☐ LOW BLOOD PRESSURE
- ☐ PALPITATIONS
- ☐ SHORTNESS OF BREATH
- ☐ SWELLING OF LEGS
- ☐ VARICOSE VEINS

**GENITOURINARY**

- ☐ DENY ALL
- ☐ BURNING URINATION
- ☐ CRAMPS
- ☐ FREQUENT URINATION
- ☐ HESITANCY/DRIBBLING
- ☐ HORMONE THERAPY
- ☐ IRREGULAR MENSTRUATION
- ☐ LACK OF BLADDER CONTROL
- ☐ PROSTATE PROBLEMS
- ☐ URINE RETENTION
- ☐ VAGINAL BLEEDING
- ☐ VAGINAL DISCHARGE

**ENDOCRINE**

- ☐ DENY ALL
- ☐ DIABETES
- ☐ EXCESSIVE APPETITE
- ☐ EXCESSIVE HUNGER
- ☐ EXCESSIVE THIRST
- ☐ GOITER
- ☐ HAIR LOSS

**NEUROLOGICAL**

- ☐ DENY ALL
- ☐ CHANGE IN CONCENTRATION
- ☐ CHANGE IN MEMORY
- ☐ DIZZINESS
- ☐ HEADACHE
- ☐ IMBALANCE
- ☐ LOSS OF CONSCIOUSNESS
- ☐ LOSS OF MEMORY
- ☐ NUMBNESS/TINGLING
- ☐ SEIZURES
- ☐ SLEEP DISTURBANCE
- ☐ SLURRED SPEECH
- ☐ STRESS
- ☐ STROKES
- ☐ TREMORS

**RESPIRATORY**

- ☐ DENY ALL
- ☐ ASTHMA
- ☐ BRONCHITIS
- ☐ DRY COUGH
- ☐ PRODUCTIVE COUGH
- ☐ COUGHING UP BLOOD
- ☐ DIFFICULTY BREATHING
- ☐ PNEUMONIA
- ☐ SPUTUM PRODUCTION
- ☐ WHEEZING

**ENMT**

- ☐ DENY ALL
- ☐ BAD BREATH
- ☐ DENTURES
- ☐ DIFFICULTY SWALLOWING
- ☐ EAR DRAINAGE
- ☐ EAR PAIN
- ☐ FREQUENT SORE THROATS
- ☐ HEAD INJURY
- ☐ HEARING LOSS
- ☐ HOARSENESS
- ☐ LOSS OF SMELL
- ☐ LOSS OF TASTE
- ☐ NASAL CONGESTION
- ☐ NOSE BLEEDS
- ☐ SINUS INFECTIONS
- ☐ RUNNY NOSE
- ☐ SNORING
- ☐ SORE THROAT
- ☐ RINGING IN EARS

PATIENT NAME: DOB: ACCT #:

DOCTOR SIGNATURE: _____

# PERSONAL HISTORY FORM

1. Do you smoke? Yes No How much? _____
2. Do you drink alcohol? Yes No How much? _____
3. Do you do any recreational drugs? Yes No How much? _____
4. Do you exercise? Yes No How much? _____

Who have you seen as your primary care/medical doctor?
_____

Location: _____Telephone: _____

Past Hospitalizations: (list date and reason)
___/___/___/ _____
___/___/___ _____
___/___/___ _____

Past Surgeries: (list date and reason)
___/___/___ _____
___/___/___ _____
___/___/___ _____

Past Fractures: (list date and reason)
___/___/___ _____
___/___/___ _____
___/___/___ _____

List any chronic diseases you may have: _____
_____

Are you currently taking any prescription drugs? [ ] Y [ ] N
Please list:
_____ _____
_____ _____

Dr. Signature: _____ Date: _____

Patient Name: _____ DoB: _____ Pt. Acct #:_____

# Patient Health Questionnaire - PHQ

***Patient Name*** _____ ***Date*** _____

***1. Describe your symptoms*** _____

_____

*a. When did your symptoms start?* _____

*b. How did your symptoms begin?* _____

***2. How often do you experience your symptoms?***

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

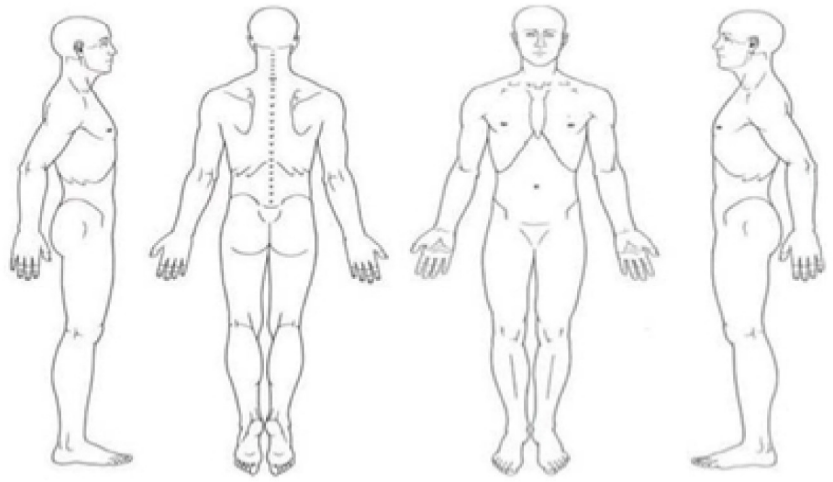
***3. What describes the nature of your symptoms?***

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

***4. How are your symptoms changing?***

① Getting Better
② Not Changing
③ Getting Worse

***Indicate where you have pain or other symptoms***




***5. During the past 4 weeks:***

*a. Indicate the average intensity of your symptoms*

*b. How much has pain interfered with your normal work (including both work outside the home, and housework)*

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

***6. During the past 4 weeks how much of the time has your condition interfered with your social activities?***
*(like visiting with friends, relatives, etc)*

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

***7. In general would you say your overall health right now is...***

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

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***8. Who have you seen for your symptoms?***

① No One
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

*a. What treatment did you receive and when?* _____

*b. What tests have you had for your symptoms and when were they performed?*

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

***9. Have you had similar symptoms in the past?***

① Yes ② No

*a. If you have received treatment in the past for the same or similar symptoms, who did you see?*

① This Office
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

***10. What is your occupation?***

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

*a. If you are not retired, a homemaker, or a student, what is your current work status?*

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

***Patient Signature*** _____ ***Date*** _____

*Crossroads Wellness & Rehab*

# OFFICE & FINANCIAL POLICY

**Thank you for choosing our office for your health care. We are dedicated to providing you and your family with the highest quality of care, using state of the art treatment in a comfortable and professional environment. Please familiarize yourself with the policies of our office. This form must be read and signed before treatment is rendered. Please ask questions if you do not understand any of these policies.**

## PATIENTS WITHOUT INSURANCE

We request that 100% of the first visit be paid at the time of the visit. On other visits, payment plans are available upon signature of agreement. We will accept Care Credit, a no interest financing program designed for your convenience, if you have it available to you.

## GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain of what your insurance covers, although most policies do provide coverage for Medical, Chiropractic & Physical Rehab. The amount they pay varies from one policy to another. When possible or mandated, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment and are not always quoted correctly. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles, co-insurance or co-pays. If your insurance is retroactively terminated for any reason, and payment is recouped from your insurance company, the amount for services will be due by you immediately.

## "ON THE JOB" INJURY (Worker's Compensation)

If you are injured on the job, your care could be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees for services are due immediately.

## PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.
4. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six (6) months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

## MEDICARE

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractic care is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met.

You are required to pay the deductible and the remaining 20% co-insurance. For chiropractic services, any services we provide other than the manipulation of the spine are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

(CONT)

**SECONDARY INSURANCE**

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

**MANAGED CARE PLANS**

We are preferred providers for BCBS, United Health Care, Cigna, Medcost and many more. If you have presented us with an insurance for a payor we are not participating with, we will file your insurance for any "out-of-network" benefits.

***FLEX PLANS/MEDICAL SAVINGS ACCOUNTS***

Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement.

***APPOINTMENTS***

In order to provide the most efficient care; we work within an appointment system. Our office hours are M, W, TH 7:30a-6:00p, T 10:00a-12:00p, 3:00p-6:00p and F 7:30a-11:00a. We make every effort to honor all time commitments and expect that patients extend the same courtesy to us. We are available when emergencies arise and will do our best to give prompt consideration as needed. We aim to give you all the time and attention you need while in our office. If you are more than 15 minutes late for your scheduled appointment, we may need to reschedule to allow time for your treatment.

***CANCELLATION POLICY***

If you are unable to keep your scheduled appointment for any reason, please notify the office at least twenty-four (24) hours in advance of your scheduled appointment time. Please note schedule changes will be accepted only during regular office hours. Please be aware that you will be charged a fee if you do not provide twenty-four hours notice of cancellation or do not show up for an appointment. The fee will vary depending on the amount of time scheduled and will not be less than $50.00. If you fail to show up for two (2) appointments, we may not be able to schedule you for future appointments.

***INSURANCE FORMS/PAYMENT***

*If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.*

I have read and understand the payment policy of Crossroads Wellness & Rehab. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Crossroads Wellness & Rehab and my insurance company. I request that Crossroads Wellness & Rehab prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctor at Crossroads Wellness & Rehab that fees will be due and payable immediately. I understand that this office offers flexible payment plans to fit in my budget. Once I have chosen a payment option I agree to the terms and understand that in the event of default on a payment plan my balance will be due in full and care will be discontinued until payments are up to date. Any balance past due more than 30 days will be subject to 1.5% interest per month.

_____ _____

Patient's signature (or guardian if patient is a minor) Date Witness

Patient's Name:_____ DOB: _____ ACCT: _____

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT** Crossroads Wellness & Rehab 58 Old Roberts Road, Benson, NC 27504

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date _____ Attempt _____

Staff Name (print) _____

Staff Initial _____

# CHIROPRACTIC TREATMENT AND ITS RISKS

## Nature of Chiropractic Treatment

Prior to beginning treatment, you will be given a physical examination that can include taking vital signs, range of motion testing, muscle strength testing, palpation, orthopedic testing, neurological testing and X-rays. Once your condition has been diagnosed, the primary method of treatment will be spinal manipulation, also known as spinal adjustment. An adjustment is a quick, precise movement of the spine over a short distance. Adjustments are usually performed by hand but may be performed by handguided mechanical instruments. In addition to spinal manipulation, treatment can also involve other forms of therapy including ultrasound, electrical stimulation, traction, hot and cold packs, hydrotherapy, infrared heat, exercise and nutritional supplements.

## Risks of Chiropractic Treatment

All health care procedures carry some degree of risk. The most common side effect of spinal manipulation is short-term muscle soreness. More serious side effects can include bone fractures, muscle strain, ligament sprain, joint dislocation and injury to the discs, nerves or spinal cord. Some manipulations of the upper spine have been associated with injury to the arteries in the neck, which could cause or contribute to stroke. However, documented cases are exceedingly rare, and it has been estimated by researchers that the probability of a spinal adjustment causing a stroke is one in several million.
As for chiropractic therapies other than spinal manipulation, the risks are also very slight but can include skin irritation or burns. Compared to other forms of health care, chiropractic is extremely safe, and complications are generally rare.

## Treatment Options Other Than Chiropractic

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics;
- Medical care and prescription drugs such as muscle relaxers, pain killers and drugs to reduce inflammation;
- Surgery;
- Remaining untreated.

If you decide to pursue other treatment options, you should discuss the risks and benefits with your medical physician. Remaining untreated carries its own risks and may allow the formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce mobility and induce chronic pain cycles.
Unusual Risks:
If your pre-treatment examination reveals any health issues that would make some forms of chiropractic treatment inadvisable (contra-indicated), your chiropractor will explain the risks to you and answer any questions you may have.

By Signing below you are indicating that you have read and understand the above disclosure.

Name: _____ Date: _____ ACCT: _____

# *PATIENT WAIVER FOR NON-COVERED SERVICES*

Patient's Name: _____ ACCT #: _____

Your insurance does not pay for all your healthcare costs. Some items and services are not considered "covered benefits" under your health insurance plan and as such, your insurance will not pay for these services.

Your physician believes that the following service(s), although not covered by your health insurance, are an important part of your chiropractic care and recommends that you receive these services as part of your current treatment plan. However, since the services listed here are not considered to be a covered benefit under your health insurance, should you choose to receive these services; you will be personally responsible for the payment of such services. The purpose of this notice is to help you make an informed choice about whether you want to receive these items or services.

The services recommended by your physician are listed below:

| | | |
|---|---|---|
| ☐ | X-Rays | $60.00 |
| ☐ | Decompression Therapy | $65.00 / $45.00 |
| ☐ | Dry Needling | $50.00 / $35.00 |
| ☐ | Laser Treatment | $15.00 |
| ☐ | Cupping Treatment | $15.00 |
| ☐ | Shockwave Package (6 Treatments) | $600.00 |

I acknowledge that I have been informed in advance of receiving these services, that these services are not covered by my health insurance plan. I have chosen to receive these services and understand that I will be financially responsible for the charges indicated above.

Print Patient Name _____

Patient Signature _____

Name of Parent or Legal Guardian (if applicable) _____

Signature of Parent or Legal Guardian (if applicable) _____

Date_____

**This form must be signed by the patient or legal guardian PRIOR to receiving any non-covered services or items and *must be maintained in the patient's medical record.***