Phone: (301) 217-0515

PROACTIVE CHIROPRACTIC

1201 SEVEN LOCKS ROAD, SUITE 212
ROCKVILLE, MD 20854
Phone: 301-217-0515- Fax: 301-217-0585
www.prochiromed.com

Thank you for scheduling an appointment with Proactive Chiropractic and Physical Therapy. It is my pleasure to welcome you in advance of your first visit at our office. The following is some information to familiarize you with our practice. Please read and complete this packet carefully.

Providers

Joseph A. Pollack, D.C.
Ryan J. Mullen, D.C.
Marshall A. Dispenza, D.C.
Yi Ju Chen, D.P.T.

Assistants

Kimberly Rea, P.T.A.
Yoshiko Spratley, C.A.

Massage Therapist

Carole Dean, L.M.T.

Office Hours:*

Monday through Thursday: 7:00am- 7:00pm
Friday: 7:00am- 5:00pm

**Each provider has their own schedule during these hours depending on the day of the week. Please call for specific hours*

To Prepare For Your Initial Visit:

*Please bring your intake forms, license/photo ID, referral (if required) and health insurance card(s). If you are a personal injury claim, please bring ALL of your claim information. If you are unable to complete these forms ahead of time, please plan to arrive at least 30 minutes early so as not to cut into your appointment time filling out forms. Most patients prefer to wear comfortable clothing and shoes to their appointment.

IMPORTANT: Our suite (212) is located in the back of the building. There is no access if you enter through the main lobby, so please drive around to the back of the building and park near the large black ramp. We are up the stairs and to the left. If you need more specific directions, please utilize our website.

If you have any further questions, I will be happy to answer them for you prior to your appointment. Once again, we greatly appreciate you selecting Proactive for your chiropractic, physical therapy, and massage therapy care. We look very forward to meeting you!

Sincerely,

Kristen Martin
Office Manager

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Date: ____/____/____ Patient's Full Name: ________________

Home Phone: __________ Cell Phone: __________ E-Mail: __________

☐Male ☐Female Age: ____ Date of Birth: ____/____/____ Social Security #: ____ - ____ - ____

Address: ________________ City: ________ State: ____ Zip: ______

How would you like to be addressed by our staff? ________________

☐Married ☐Single ☐Widowed ☐Separated ☐Divorced Number of Children: ____ Ages: ______

Occupation: __________ Employer: __________ Business Phone: __________

Emergency Contact: ________________ Relationship: __________

Phone: __________ City: __________ State: ________ Zip: ________

Family Physician: ________________ Address: ________________

City: __________ State: ________ Zip: ________ Phone: ________

May our office inform your physician of our exam findings, diagnosis, and treatment plan? ☐Yes ☐No

Whom may we thank for referring you? ________________

CHIEF COMPLAINT

(No, you can't just say your "husband" or "wife")

Chief complaint: ________________

Secondary or related complaint(s) if any: ________________

Was the **Onset**: ☐Gradual ☐Sudden

Since the onset, has it gotten: ☐Worse ☐Stayed same ☐Better

When did this bout **begin**? ________

Has this occurred before: ☐Yes ☐No

How long ago since first occurrence? ____ (please circle) months / years ago

What **caused** the pain: ☐no apparent cause ☐one incident ________________

How **intense** is the pain: ☐Minimal ☐Mild ☐Moderate ☐Severe/Excruciating

Have you had any changes in bowel or bladder functioning? ☐Yes ☐No

Have you been treated for your present problem in the past? ☐Yes ☐No

If yes, when: ________ If yes, by whom: ________________

Outcome: ☐No effect ☐Somewhat better ☐Resolved

What does your condition prevent you from normally doing? ☐sitting/driving ☐walking ☐running ☐golfing ☐swimming ☐weight lifting ☐work ☐playing with children ☐sleeping ☐normal activities of daily living ☐other: ________________

What is your long-term goal from treatment (e.g. play a round of golf without pain)? ________________

____

Do you want this pain gone? ☐Just now ☐Forever

Is there anything else I should know? ________________

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Describe the **quality** of the complaint/pain:
- ☐ sharp/ stabbing
- ☐ dull/ache
- ☐ pulling/tight
- ☐ tingling/numbness
- ☐ burning/throbbing
- ☐ other: ______________________

Describe the **location** of the symptoms:
- ☐ generalized dull, deep ache
- ☐ pin point
- ☐ pain starts localized, but then radiates
  Describe: ______________________
- ☐ other: ______________________

The symptoms are:
- ☐ more prevalent in the morning
- ☐ more prevalent at night
- ☐ better as the day goes on
- ☐ worse as the day goes on

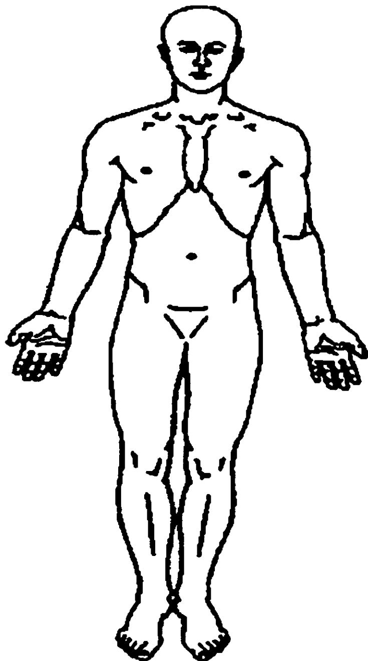
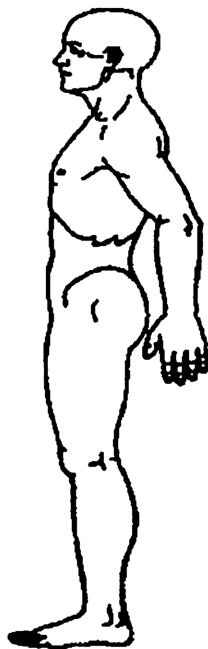
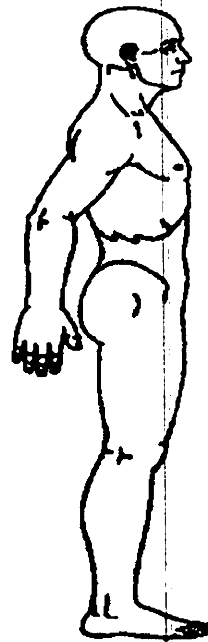
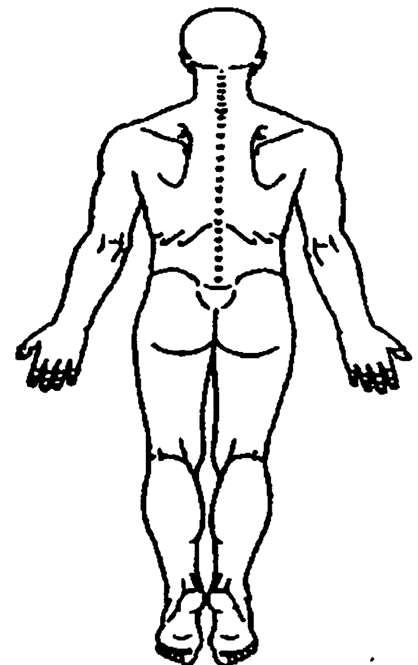
How often daily are you aware of the symptoms:
- ☐ intermittent (less than 25% of time)
- ☐ occasional (25-50% of time)
- ☐ frequent (50-75% of time)
- ☐ constant (75-100% of time)

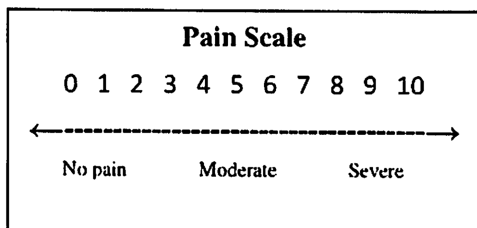
Does any of the following make the **pain worse**:
- ☐ lifting/pushing/pulling
- ☐ cough/sneeze/bowel movement
- ☐ driving/riding/sitting
- ☐ walking/running/standing
- ☐ bending forward/leaning back
- ☐ other: ______________________

Does any of the following make the **pain better**:
- ☐ rest/laying down
- ☐ sitting
- ☐ walking/exercise
- ☐ standing
- ☐ other: ______________________
- ☐ ice
- ☐ heat
- ☐ aspirin

The symptoms feel:
- ☐ better with exercise/activity
- ☐ worse with exercise/activity
- ☐ no change with exercise/activity

Does it interfere with your daily activities:
- ☐ minimal (annoyance, no impairment)
- ☐ slight (tolerated, some impairment)
- ☐ moderate (marked impairment)
- ☐ marked (preclude any activity)



Pain Scale

0 1 2 3 4 5 6 7 8 9 10

No pain — Moderate — Severe

Use the following letters to indicate the type and location of discomfort:

A - Aching
B - Burning
N - Numbness/Tingling
P - Pins and Needles
S - Stabbing/Sharp
T - Throbbing
O - Other

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STRESSORS

What **medications** are you currently taking? ____________________

What **vitamins/supplements** are you currently taking? ____________________

How many night per week do you drink **alcohol**? ______ On those nights, how many drinks do you have?________

Do you smoke **cigarettes**? ☐Yes ☐No

How much **mental stress** do you experience? ☐Mild ☐Moderate ☐Severe

Do you eat **vegetables** with every meal? ☐Always ☐Sometimes ☐Never

What **general physical** activity do you do? ☐ No regular exercise ☐ Light exercise ☐ Strenuous exercise

What type of physical activity do you do? ☐ Cardiovascular Resistance Walking ☐Other _______

Females only: Are you currently pregnant? ☐Yes ☐No

In general, would you say your health is (check one): ☐Excellent ☐Very good ☐Good ☐Fair ☐Poor

PAST HEALTH HISTORY

Previous Chiropractic Care: ☐Yes ☐No If Yes, for what Problem: ____________________

What treatment(s) were received: ____________________Were they helpful? ☐Yes ☐No

Doctor's Name: ____________________ Address: ____________________

City: ______________ State: __________ Zip: __________ Phone: __________

Please list any major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries.

Date	Injury/Fracture/Illness/Surgeries/Falls	Treatment	Results

Please indicate any of the following illnesses you have had or currently have with approximate dates.

High Blood Pressure______________ Prostate disease______________ Multiple Sclerosis______________

Heart disease______________ Ulcer______________ Headaches______________

Stroke______________ Allergies______________ Cancer______________

Diabetes______________ Scoliosis______________ Seizures______________

Kidney disease______________ Mental/Emotional______________ Auto accident______________

Fevers ______________ Upset stomach ______________Other______________

Signature of Patient: ____________________ ***Date***: ______________

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-----------INFORMED CONSENT---------------

I (PRINT NAME)____________ hereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand and I am informed that, as is with all healthcare treatments, results are not guaranteed and there is no promise to a complete cure. I further understand and I am informed that, as is with all healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fractures (in isolated cases, fractures may result from treatment), muscle soreness, strokes(there has never been a link between chiropractic treatment and stroke, however it has been reported to occur once in one million to once in ten million treatments), and bruising. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments, or payments made in excess of an insurance's allowed amount, will be refunded if I wish to cancel the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature______________________ Date____________________

Parent/Guardian Signature(if patient is a minor)________________ Date____________

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HIPPA NOTICE OF PRIVACY PRACTICES

YOUR HEALTH INFORMATION RIGHTS:

Unless otherwise required by law, your record is the physical property of the healthcare practitioner or facility that compiled it, but the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information and request amendments to your health records. You may also request a copy of your medical records at any time.

This organization is required to maintain the privacy of your health information. We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We will not use or share your information without consulting you first. If you tell us we can, you may change your mind at any time. Please let us know in writing if you change your mind.

Patient Printed Name_______________________________
Signature_____________________________ Date_______________

Parent/Guardian Name Printed_____________________________
Signature___________________________ Date________________

PAYMENT OPTIONS

(Please INITIAL next to the payment option you're using)

Private Pay: Not using insurance; I am paying by cash, check or credit card at the time of service. _________ (initials)

You have been offered the opportunity to personally pay for your treatment at Proactive Chiropractic and PT. The private pay policy is used in the following circumstances: 1. Patient has no insurance 2. Chiropractic/PT treatment is not covered by your insurance 3. Patient chooses to forego insurance benefits. The following conditions apply: 1. Once you have chosen the private pay terms, we will not bill your insurance carrier for services rendered. 2. Payment is due at the time of service. We accept cash, checks, and all major credit cards. There is a $25.00 service charge for returned checks. 3. The cash rate collected in office is discounted from the insurance's max allowed amount. If payment is not paid at the time of service, you will be billed the full allowed amount of the claim 4. Initial Evaluation: $125. Subsequent treatments: $75. *Please ask about packages that reduce the cost of follow ups per visit.* If you have not been seen in the office for 2 years or more, you are considered a new patient and the evaluation cost applies.

Health Insurance: I would like Proactive to submit my claims to my health insurance on my behalf__________ (initials)

Primary Health Insurance Company: _____________ Phone #:________________
Plan ID #: ________________________________ Group Number: _________
Policy Holder: _________________ Relationship:________ Policy Holder DOB: ____ / ____ / _____

Secondary Insurance Company: _________________Plan ID #: __________ Policy Holder:_______
Policy Holder DOB:_______________ Relationship:____________________

Statement of Financial Policy

Welcome to Proactive Chiropractic and Physical Therapy. We assure you that you will receive the very best care available for your condition. The following information will familiarize you with the financial policy of this office and how your medical bills will be handled. A copy of this form is available upon request.

Explanation of Insurance Coverage/Insurance Billing: As a courtesy, we can file your insurance claims for you and agree to your insurance company's fee schedule when processing their payment. Reduced allowed amounts only apply in network. We will submit out of network, but the patient responsibility may be a bit higher. We suggest that you contact your insurance carrier prior to your first scheduled appointment to verify chiropractic and physical therapy coverage. Regardless of your insurance coverage, your policy is a contract between you and your insurance carrier. ***You are ultimately responsible for payment which may include a copay, coinsurance, and/or deductible. If your claim is denied due to lack of coverage or your insurance company does not pay for the services rendered, you will be responsible for the entire balance on your account.***

Payment Arrangements: Any copay/coinsurance/deductible costs are due at the time of service. We accept cash, major credit cards, and checks.

Appointments and Cancellation Policies: We realize that on rare occasions you may need to reschedule or cancel an appointment. We request that you contact our office within 24 hours if you are unable to attend a chiropractic or PT appointment. You can contact us at (301)-217-0515 to cancel or reschedule. Please leave a message on our voicemail after hours or on weekends, if necessary. **If you do not show up for your appointment or call to cancel within 24 hours, a $60 fee will be billed directly to you.**

Authorization for Payment/Assignment of Benefits: I hereby instruct Proactive Chiropractic and PT to bill my insurance company for services rendered and said insurance company to make direct payment of medical benefits to: Proactive Chiropractic, 1201 Seven Locks Rd, Ste 212, Rockville, MD 20854. ***I also understand that should my insurance company send payment to me, I will forward the payment to Proactive within 48 hours of receipt.*** I agree that if I fail to send the payment to the Proactive and they are forced to proceed with the collections process, I will be responsible for any cost incurred by the office to retrieve their monies. I authorize Proactive to initiate a complaint to the insurance commissioner for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials. A fee of $25.00 will be charged on all returned checks.

Printed Name:________________ **Signature:**__________________ **Date:**__________________

Understanding Common Health Insurance Terms

While your health insurance plan covers fees for health care services, there may still be certain dollar amounts that you will be responsible for paying, including deductibles, co-pays and co-insurance.

Deductible

A deductible is a dollar amount established by your health insurance plan that you are required to pay out-of-pocket before your plan kicks in and starts to pay for your health care services.

Example: Your health plan has a $1,500 deductible. This means you must pay 100% of your health care fees until you spend $1,500. Once you meet your deductible, then your insurance plan will begin paying the fees for your health care services. However, each insurance plan is different, and some plans may pay for 100% of the fees for services, while others may only pay a percentage. In addition, you may still be responsible for paying co-insurance or co-pays established by your health plan.

Co-Pay

A co-pay is a set dollar amount that you must pay for each doctor visit, prescription, medical equipment or other health care service. Your co-pay is usually due at the time of service and may vary by the type of service you receive.

Example: Your co-pay for a visit to the doctor's office might be $40; while a prescription co-pay could be only $10, and an emergency room visit may be $100. Your insurance plan establishes a maximum dollar amount that you will pay out-of-pocket for co-pays.

Co-Insurance

Co-insurance is your share of the cost for a health care service after you have met your deductible and co-pay fee. Some health plans may have an 80/20 co-insurance, while others may have a 50/50 co-insurance.

Example: You have met your $1,500 deductible and paid your $40 co-pay for an office visit. Your co-insurance is 80/20 and you have a $100 medical bill. This means you are responsible for paying $20 and your health plan pays the remaining $80 of the bill.

Out-of-Pocket Limit

Out-of-Pocket Limit is the maximum amount of money you will pay for medical services in a policy period, which is usually one year. Once you meet the out-of-pocket limit, your health plan starts to pay 100% for covered health services.

Please contact your health plan with specific questions about your insurance coverage.

PERSONAL INJURY PATIENTS

(Please initial below next to the personal injury option you are using)

***Auto Accident/ Personal Injury:* I was involved in an auto accident and have an open claim with medical benefits available. I authorize Proactive to submit my bills to car insurance and/or a lawyer _____________ (initials)**

*Car Insurance Carrier:*__________________*Date and State of Accident:*________________

*Claim #:*_____________ *Adjuster name:* _______________ *Ph #:*____________ *Fax #:*______

*Lawyer Name:*__________________ *Ph#:*__________________ *Fax#:*______________

***Worker's Compensation:* I was injured in the course of employment and have an open claim to receive medical benefits through my employer _________(Initials)**

WC Insurance Carrier: __________________________________ Date of Incident:__________

Claim #:_____________ Name of Adjuster: _________________________

Ph #:_________________________________ Fax#:______________________________

Phone # and name of Employer Insuring The Claim: ___________________________

Proactive Chiropractic and Physical Therapy accepts personal injury cases under the following conditions: 1. Medical benefits are open and available on the patient's own auto insurance under personal injury protection. If the patient has waived PIP, a third party car insurance has agreed to cover medical costs, or the patient has an attorney. In addition, patient must have: **a. Private health insurance that will be billed for treatment in the event that the medical benefits on their auto policy are exhausted,** or b. The patient understands that all bills that are not paid by any of the above become their full responsibility. 2. If patient is using private health insurance, they will be responsible for any copay, coinsurance, and/or deductible dictated by their insurance plan. 3. Patients who have a lawyer understand that Proactive will allow 18 months for settlement before the patient is billed in full.

I have read the above information and by signing below consent to financial responsibilities, release of information, assignment of benefits, and acknowledgment of privacy practices.

Printed Name:______________ **Signature**____________________ **Date:**________

Provider Use Only*

Recommendations: __________x/wk for __________ wks

Special Instructions:

Signature______________________________________ **Date:**_____________