

PATIENT'S PRESENT COMPLAINTS

Name _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Telephone _____ Social Security# _____ Driver Lic.# _____
 Age _____ Birthdate ____/____/____ Sex M / F Status M S W D No. Children _____
 Occupation _____ Employer _____ Years Employed _____
 Address _____ City _____ State _____ Zip _____
 Spouse's Name _____ Occupation _____ Employer _____ Soc. Sec.# _____
 Person Responsible for this Account _____ Health Plan _____
 Subscriber's Name _____ ID# _____ Group# _____

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. DESCRIBE YOUR PRESENT COMPLAINT. This information is necessary to assist your health care provider understand your health condition.

Please describe your problem and how it began. Date problem began: ____/____/____

How bad is your pain? (Circle a number)	0	1	2	3	4	5	6	7	8	9	10
	No Pain										Unbearable Pain

How often are your symptoms present? Constantly Frequently Occasionally Intermittently

Describe your current pain/symptoms: Sharp/Stabbing Throbbing Aches
 Dull Soreness Weakness
 Numbness Shooting Gripping
 Burning Tingling Other _____

Since it began, is your problem: Improving Getting Worse No Change

What makes the problem better? Nothing Lying Down Walking
 Standing Sitting Movement
 Exercise Inactivity/rest Other _____

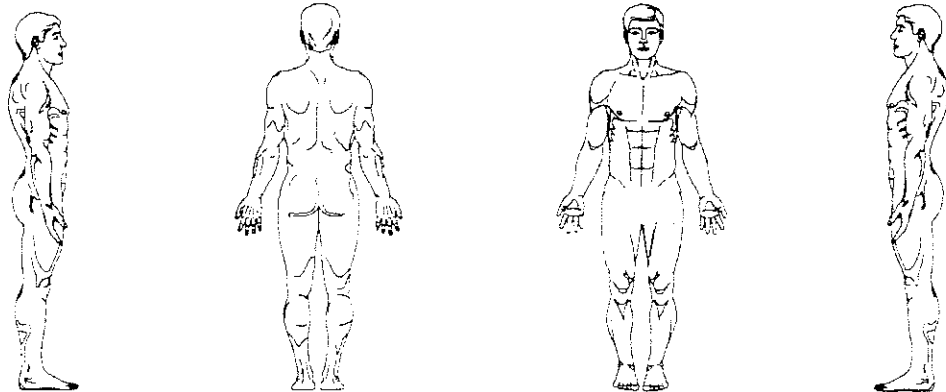
What makes the problem worse? Nothing Lying Down Walking
 Standing Sitting Movement
 Exercise Inactivity/rest Other _____

Can you perform your daily home activities? Yes Yes, only with help Not at all
 Do you exercise? Yes, almost daily Yes, occasionally Not at all
 Describe your job requirements: Mainly sitting Light Labor Heavy Labor
 Can you perform your daily work activities? Yes, all activities Only some Not at all
 Describe your stress level: None to mild Moderate High

What treatment have you had for this condition in the past? (surgery, medications, injections, therapy, chiropractic)

Have you had X-rays, MRI or other tests for this condition? What tests and When? _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING



Patient Signature: _____

Date: _____

PATIENT'S HEALTH QUESTIONNAIRE

Patient Name _____

Patient ID# _____

If you have ever had a listed symptom in the *past*, please check that symptom in the *Past Column*. If you are *presently* troubled by a particular symptom, check that symptom in the *Present column*. **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.**

Past	Present	Condition	Past	Present	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Arm or Elbow (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	Angina
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack (date) _____
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke (date) _____
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Leg or Hip (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Lower Leg or Knee (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	Tumor, Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Ankle or Foot (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Swelling, Stiffness of Joint(s)	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema (chronic lung disorders)
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/>	Liver / Gallbladder problems
<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (Ear Noises)	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders (by condition)
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Colitis
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Colon
		<input type="checkbox"/> Gain <input type="checkbox"/> Loss	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	If a family member has had any of the following, please mark the appropriate box:		
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis			
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue			
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menstrual Flow			
<input type="checkbox"/>	<input type="checkbox"/>	Profuse Menstrual Flow			
<input type="checkbox"/>	<input type="checkbox"/>	Breast <input type="checkbox"/> Soreness <input type="checkbox"/> Lumps			
<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis			
<input type="checkbox"/>	<input type="checkbox"/>	PMS			
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control			
<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination			
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination			
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain			
<input type="checkbox"/>	<input type="checkbox"/>	Constipation/irregular bowel habits			
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in Swallowing			
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Indigestion			
<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash			
			<input type="checkbox"/>	<input type="checkbox"/>	Cancer
			<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
			<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
			<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems
			<input type="checkbox"/>	<input type="checkbox"/>	Lung Problems
			<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
			<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
			<input type="checkbox"/>	<input type="checkbox"/>	Chronic Back Problems
			<input type="checkbox"/>	<input type="checkbox"/>	Chronic Headaches
			<input type="checkbox"/>	<input type="checkbox"/>	Lupus
			<input type="checkbox"/>	<input type="checkbox"/>	Other _____

If a family member has had any of the following, please mark the appropriate box:

<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Chronic Back Problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Chronic Headaches
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Lupus
<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Other _____
<input type="checkbox"/> High Blood Pressure	

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a permanent disability rating?
		Location _____
<input type="checkbox"/>	<input type="checkbox"/>	Date rating received ____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Rating Percentage _____%

Present Weight _____ pounds Height _____ feet _____ inches

Please check any of the following that apply to you

Past	Present		Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy, # births _____	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco
<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills, type _____	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol
<input type="checkbox"/>	<input type="checkbox"/>	Medications (list if not listed elsewhere) _____	<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Dependence
		_____	<input type="checkbox"/>	<input type="checkbox"/>	Coffee/Tea/Caffinated Soft drinks: cups/cans per day _____
<input type="checkbox"/>	<input type="checkbox"/>	Hospitalizations/Surgical Procedures (list if not described elsewhere) _____			

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverages in the future.

Patient's Signature: _____ Date: _____

PATIENT HISTORY

Name: _____ Referred By: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Birthdate: _____ Sex: _____ Age: _____ Marital Status: _____ # of Children: _____
Employer: _____ Occupation: _____ Work Phone # _____
Social Security #: _____ California Driver's License # _____
Email address: _____ (YOUR EMAIL ADDRESS WILL NOT BE SHARED WITH ANYONE.)

PLEASE FILL IN THE APPROPRIATE SPACES (All information you give is confidential):

MAJOR COMPLAINT

How long have you had this condition? _____
Have you lost work days because of this condition? Yes () No () How many? _____
Is the injury related to: Work accident () Auto accident ()
When have you last seen a chiropractor? _____ Dr.: _____
Why did you see this chiropractor? _____ Were you helped? _____
What spinal maintenance programs were you given to follow to maximize the future stability of your spine?

Did you follow the program? _____ If not, why? _____

Why are you changing chiropractors? _____

WHAT IS YOUR HEALTH PHILOSOPHY? (What should you do to be healthy?) _____

HOW DO YOU WANT US TO HANDLE YOUR PROBLEM? _____

_____ Temporary Relief (Help the symptom but do not fix the cause of the problem)
_____ Maximum Correction (Correct the cause of the problem for maximum stability in the future)

WHY DID YOU COME INTO OUR CLINIC AND WHAT ARE YOUR EXPECTATIONS OF US?

What are your favorite activities or hobbies to do now? _____

Are your current problems affecting these activities or hobbies? _____

What activities are you looking forward to doing in retirement? _____

On a scale of 1 – 10 (10 being the most, and 1 being the least):

____ How committed are you to being at your maximum health potential?

____ How important is it for your family to be at their maximum health potential?

____ How committed are you to preventing arthritis and maximizing your spinal stability?

What surgeries have you had? _____

List drugs or supplements you now take (prescription & non prescription): _____

Name other doctors you have seen for this condition: What was done, and for how long? _____

PLEASE FEEL FREE TO DISCUSS OUR FEES. FEES ARE PAYABLE WHEN SERVICES ARE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE IN ADVANCE.

Signature: _____ Date _____

INFORMED CONSENT

It is our responsibility to fully inform you of your treatment. Part of this includes a discussion of any potential side effects or complications. All treatments potentially can cause these reactions, and chiropractic manipulation is no different. It, however, has one of the safest records of the wide range of treatments that can be used for spinal disorders. Please feel free to ask the Doctor if you need any clarification.

Possible adverse effects of spinal manipulation can include soreness in the area of treatment, reactive muscle spasm, injury to the disc causing pressure on nerve tissue, fractures in weakened bones such as ribs, and injury to arteries in the neck resulting in stroke. Soreness or reactive muscle spasm or tightening are common but usually brief reactions to treatment. The other potential complications are rare. It is best to examine the frequency of these potential complications versus the relative frequency of the complications of the other typical treatments which may be used for a spinal disorder.

DISC INJURY from manipulation causing spinal cord pressure

1 per 100 million cases

1 per 400 million (cmt)

ARTERY INJURY from manipulation causing stroke

1 per 1 million

NEUROLOGICAL complication from

Neck Surgery 1 per 64 (cases)

Back Surgery 1 per 333 (cases)

DEATH RATE from neck surgery

1 per 145

Perhaps the most common alternative to spinal manipulation is the use of anti-inflammatory drugs or NSAIDs. These drugs cause fairly common and can also potentially cause serious complications.

COMPLICATIONS ASSOCIATED WITH ANTI-INFLAMMATORY DRUG USE	
Serious stomach or intestinal bleeding	1-4 per 100 users
Hospitalizations from complications	20,000 per year
Deaths from complications	2,600 per year

I have read the above and understand the risk of complication that may occur from spinal manipulation. With this understanding, I consent to treatment with spinal manipulation by Eric Belusa, DC or any DC at Performance Chiropractic.

Signature

Date

Disclosure of Fees/ Payment Policy

99201	Brief Initial History and Consultation	60.00
99202	Brief Initial History and Exam	75.00
99203	Intermediate Initial History and Exam	100.00
99204	Comprehensive History and Exam	140.00
99211	Min. Office Visit/ Re-evaluation (not needing doctors presence)	35.00
99212	Brief Office Visit/ Re-evaluation	45.00
99213	Limited Office Visit/ Re-evaluation	55.00
99214	Intermediate Office Visit/ Re-evaluation	80.00
97026	Infrared Hot/ Cold	35.00
97035	Ultrasound/ Iontophoresis 15 minutes or less	45.00
97032	Muscular Stimulation 15 minutes or less	55.00
97124	Vibromassage	15.00
97124	Massage Therapy 15 minutes or less	30.00
97250	Myofascial Release 15 minutes	50.00
99012	Mechanical Traction	30.00
98940	Manipulation 1-2 Areas	60.00
98941	Manipulation 3-4 Areas	75.00
98943	Extra Spinal Manipulation	60.00
98940-52	Office Visit/ Manipulation	55.00
98940-52	Family Wellness Plan	
98940	Medicare Spinal Manipulation 1-2 Areas	29.48
98941	Medicare Spinal Manipulation 3-4 Areas	41.12
98942	Medicare Spinal Manipulation 5 Regions	52.82
72040	X-rays Cervical 2 Views	90.00
72050	X-rays Cervical 5 Views	130.00
72100	X-rays Lumbar 2 Views	100.00
72070	X-rays Thoracic 2 Views	100.00
99070	Brace and Supports	Varies
	Supplements	Varies

I have read the above codes and fees and understand and know the cost of my care with my treating doctor. I understand that I am responsible for payment of all deductibles and co-payments of my care. I further understand that it is my responsibility to know my own insurance benefits and that Performance Chiropractic is not responsible for any discrepancy between what my coverage is and what was reported to us. I understand that if I have a balance for medical services not paid, I will make a minimum payment of \$50.00 each month or 20% (auto debit) of the outstanding balance whichever is greater. If my balance is not paid in a timely and monthly fashion, I promise to pay any and all collection, court and attorney fees in the collection of my account. I further understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of the above fee schedule regardless of the outcome of the case. I understand that if a check or debit is returned for insufficient funds, I will be charged a \$25.00 service charge.

I have read and fully understand the above financial terms and prices.

Signed _____ Date _____.

Patient's Name: _____

Medicare Claim Number: _____

ADVANCE NOTICE OF NON-COVERED SERVICES

PHYSICIAN NOTICE

In accordance with the Medicare Act, Section 1842(i), this letter is to advise you that Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862(a)(i) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary," under Medicare program standards, Medicare will deny payment for that service. I believe that in your case, Medicare is likely to deny payment for:

Procedure description: Manual manipulations of the spine to correct subluxations.

Treatment plan (or dates of service): _____

The reason(s) for this denial is: Medicare may determine that these services are not reasonable and/or medically necessary.

BENEFICIARY AGREEMENT

I have been notified by my physician that he or she believes that, in my case, Medicare is likely to deny payment for services identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Patient's Signature _____ Date _____

Witness Signature _____ Date _____

✦ EXPLANATION OF NON-COVERED CHIROPRACTIC SERVICES

DEDUCTIBLE:

Medicare, Part B, requires you to pay a yearly deductible of \$ _____ towards your expenses. If you have already been treated by other doctors this year, you may apply those bills to your deductible.

WHAT MEDICARE WILL PAY FOR:

After you have met your deductible, Medicare will reimburse you for 80% of your "allowable treatment charges". The only "allowable treatment charge" for chiropractic is "manual manipulation of the spine".

Medicare guidelines state that they will only allow Chiropractic treatment is reasonable and necessary to restore or arrest the patient's covered condition. Once Medicare has determined that further manipulative treatment is not "reasonable and necessary" for your condition, you will then be responsible for all of your treatment charges.

X-RAYS:

The doctor may determine that X-rays are necessary. If they are necessary, Medicare WILL NOT REIMBURSE you for your X-rays, and payment must be made by you.

EXAMINATIONS:

In order to determine the extent of your condition, as well as the type of treatment you need, the doctor will examine you prior to the initiation of treatment. Medicare WILL NOT REIMBURSE you for this examination, however, and payment must be made by you.

PHYSICAL THERAPY, SUPPLEMENTS AND SUPPORTS:

During the course of your treatment in this office, the doctor may determine that certain physical therapy, modalities and procedures, manipulations of areas other than your spine, vitamin supplements and or orthopedic supports are necessary to assist in the treatment of your condition. Medicare WILL NOT REIMBURSE you for any of these service, however, and payment must be made by you.

I understand that although the chiropractic services listed above may be required for treatment of my condition, these charges are not covered by Medicare and I will be personally responsible for payment of these charges.

Patient's Signature: _____ Date: _____

Health and Medical Information Release Form

I, _____, give permission to Dr. Eric Belusa, his staff, associates, and employees of Performance Chiropractic to share private and medical information with my medical doctor, _____, as well as his or her staff, employees, and associates. Also, my medical doctor, as well as his or her staff, employees, and associates have permission to share personal and medical information with Dr. Belusa and his staff.

Signature: _____ Date: _____

Patient Info

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Date of Birth: _____

Medical Doctor Info

Name of Doctor: _____

Address: _____

City, State, Zip: _____

Phone: _____

PERFORMANCE CHIROPRACTIC CENTER NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Performance Chiropractic Center is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Performance Chiropractic Center."

"It is our policy to provide a substitute health care provider, authorized by Performance Chiropractic Center to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Performance Chiropractic Center for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

office at 925-687-5515 If Eric Belusa, D.C. is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of ____/____/____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Performance Chiropractic Center with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

Patient's Name (print)

Patient's Signature

Date

Authorized Facility Signature

Date

If you would like the complete document (4 pages), please ask the front desk. Thank you.