Balancing Point
Center for Wellness, PC

Confidential New Patient Form

NAME: _____ **SS#:**_____ **DATE:** _____

HOME ADDRESS: _____ **CITY:** _____ **ZIP CODE:** _____

HOME #: (_____) _____ **CELL:** (_____) _____

D.O.B.: _____/_____/_____ **AGE:** _____ **MARITAL STATUS:** S P M D W

EMAIL: _____ **HOW'D YOU HEAR ABOUT US?** _____

EMPLOYER: _____ **OCCUPATION:** _____

EMPLOYER ADDRESS & NUMBER: _____

EMERGENCY CONTACT NAME: _____ **RELATIONSHIP:** _____

HOME NUMBER: _____ **WORK NUMBER:** _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with: (insurance company) _____ and assign directly to Dr. Kristina Chung; all insurance 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 authorize the use of my signature on all insurance submissions.

The doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed for one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative Date

_____
Please **print** the name of Patient, Parent, Guardian, or Personal Representative

INSURANCE INFO –* FILL OUT ONLY IF YOU ARE NOT THE PRIMARY CARD HOLDER**

INSURANCE NAME: _____ **POLICY #:** _____

GROUP#: _____ **RELATION TO INSURED:** _____

INSURED'S NAME: _____ **INSURED'S D.O.B.:** _____/_____/_____

INSURED'S PHONE #: _____ **INSURED'S EMPLOYER/SCHOOL:** _____

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Automobile Accident Questionnaire

Name_____ Date of Birth _____ Phone Number _____

Address _____ City _____ State_____ Zip_____

Your Insurance Company _____ Policy # _____

Agent's Name _____ Agent's # _____ Claim # _____

Driver/Other Vehicle _____ Insurance Company _____ Policy # _____

Have you retained an attorney? (circle) YES NO Name_____ Phone #_____

Date of Accident_____ Time of Day_____

Please explain in detail how your accident happened:

_____

_____

_____

_____

You were the: Driver_____ Front Passenger_____ Rear Passenger_____

Number or people in your vehicle_____ Other Vehicle_____

Were you wearing a seatbelt? YES NO

Did the airbag deploy? YES NO

What direction were you heading? NORTH SOUTH EAST WEST

What direction was the other vehicle heading? NORTH SOUTH EAST WEST

Were you struck from BEHIND FRONT LEFT SIDE RIGHT SIDE

Were the police notified? YES NO

Were you knocked unconscious? YES NO If yes, for how long? _____

Did you feel pain immediately after the accident? YES NO

Where? Headache _____ Neck _____ Middle Back_____ Lower Back _____

Upper Extremities _____ Lower Extremities _____

Did you go to the hospital or urgent care? YES NO If yes, did you go by ambulance?_____

Have X-Rays been taken following this accident? YES NO

If yes, where and of what body part? _____

Have any MRI's or CT scans been taken following this accident? YES NO

If yes, where and of what body part? _____

Have you received any treatment prior to coming to this office? YES NO

If yes, what date?_____

Where?_____

What type of treatment?_____

Have you ever been in an automobile accident before? YES NO

If yes, what date?_____

If yes, are you having any residual pain?_____

Are you still under treatment for a prior accident?_____

Have you ever had similar complaints in the involved area before? _____

If yes, were they resolved?_____

Are your work activities restricted as a result of this accident? YES NO

If yes, complete Loss of Employment Questionnaire.

Did you have to take time off work as a result of this accident? YES NO

If yes, how many days have you missed as a result of this accident?_____

Have you returned to work since this accident? Full time_____ Part time_____

Full duty_____ Light duty____

Is your sleep disturbed as a result of this accident? YES NO

If yes, is it disturbed due to pain? YES NO

How many hours do you sleep at night?_____

Is it difficult to sit, stand, walk, bend or lift as a result of this accident? YES NO

How long can you : Sit for?_____ minutes or hours

Stand for? _____ minutes or hours

Walk for? _____ minutes or hours

Since this injury are you symptoms: Worse_____ Same _____ Better_____

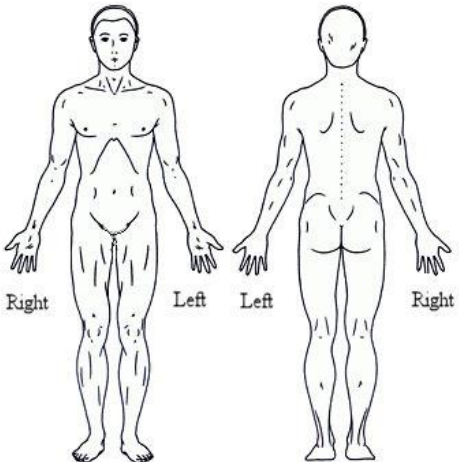
Check any/all symptoms after the accident:

- ☐ Headache
- ☐ Neck Pain
- ☐ Neck Stiffness
- ☐ Sleeping Problems
- ☐ Back Pain
- ☐ Nervousness
- ☐ Tension
- ☐ Irritability
- ☐ Chest Pain
- ☐ Diarrhea
- ☐ Upset Stomach
- ☐ Fever
- ☐ Dizziness
- ☐ Head seems too heavy
- ☐ Pins/needles in arms
- ☐ Numbness in Fingers
- ☐ Numbness in Toes
- ☐ Shortness of Breath
- ☐ Fatigue
- ☐ Depression
- ☐ Feet Cold
- ☐ Constipation
- ☐ Light Sensitivity
- ☐ Loss of Memory

- ☐ Ringing in Ears
- ☐ Face Flush
- ☐ Buzzing in Ears
- ☐ Symptoms other than above _____
- ☐ Loss of Balance
- ☐ Loss of Taste
- ☐ Hands Cold
- ☐ Cold Sweats

Using the symbols below, mark on the picture where you feel pain:

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _____	^ ^ ^



How often do you experience the pain?

- ☐ Constantly
- ☐ Frequently
- ☐ Intermittent
- ☐ Occasionally

Please rate the severity of pain by the location (10 being the most severe):

Neck	0	1	2	3	4	5	6	7	8	9	10
Middle Back	0	1	2	3	4	5	6	7	8	9	10
Lower Back	0	1	2	3	4	5	6	7	8	9	10
Arms	0	1	2	3	4	5	6	7	8	9	10
Shoulders	0	1	2	3	4	5	6	7	8	9	10
Elbows	0	1	2	3	4	5	6	7	8	9	10
Wrist/Hand	0	1	2	3	4	5	6	7	8	9	10
Legs	0	1	2	3	4	5	6	7	8	9	10
Knees	0	1	2	3	4	5	6	7	8	9	10
Ankle/Foot	0	1	2	3	4	5	6	7	8	9	10
Headaches	0	1	2	3	4	5	6	7	8	9	10

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ **ID#/SS#** _____ **Plan ID** _____ **Total Score** _____

PRINTED

_____

Signature

_____

Date

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Consent and Statement of Financial Responsibility

1. **FOR CHARGES BILLED TO INSURANCE.** ***I agree Balancing Point will charge the credit card on file for services NOT reimbursed by my insurance carrier after 45 days***. Balancing Point will collect my outstanding balances including co-pays, co-insurance, deductible and non-covered services from the credit card on file and will refund over-payments (if any) tothe credit card on file.
2. **APPOINTMENT ATTENDANCE AGREEMENT/ FEES.** I understand the importance of attending therapy consistently and arriving promptly for my appointment. I will I agree to provide a 24 hour notice in advanced when I need to cancel an appointment and that cancellation less than 24 hours or not showing up for an appointment will likely result in a cancel/no show charge of $25 per each service. I acknowledge that if I make a payment by check that has insufficient funds, I will authorize Balancing Point to collect the non-payment PLUS $50 returned check fee to the credit card on file
3. **ACKNOWLEDGEMENT FOR NON-COVERED SERVICES.** I acknowledge that my health insurance plan requires me to be responsible for Co-payments, Co-insurance and deductibles for covered services as well as those services that exceed benefit limits. I also agree that I'm financially responsible for all products and services that are considered may not be considered non-payable by my insurance company such as vitamins and wellness care, acupuncture, maintenance care, supplements and supports. I acknowledge I have been advised with the information below, and that I agree to be financially responsible for services and products rendered outside of my coverage limitations.
4. **RESPONSIBILITY FOR PAYMENT.** I acknowledge that in consideration of the services provided to me by Balancing Point Center for Wellness, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to understand with any current insurance information and familiarize myself with my insurance plan and policies and that it does not guarantee payment. Any questions I have regarding my health insurance coverage or benefits levels should be directed to my health plan.
5. **ACCESS TO AND RELEASE OF HEALTH INFORMATION.** I understand that Balancing Point Center for Wellness may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment, for payment purposes and support those who are caring me. I authorize my clinician(s) and Balancing Point administrative staff to contact other health care professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received Balancing Point's Notice of Privacy Practices and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.
6. **HIPAA AUTHORIZATION.** I acknowledge I have read and understand the ***HIPAA Patient Privacy Statement.*** In compliance with HIPAA regulations, I authorize the following individuals to receive verbal information regarding the billing of my account.

_____ _____

Name Relationship

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this Document and sign below freely and voluntarily.

_____ _____

Signature of Patient or Legally Responsible Person Date

_____

Printed name of above

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Patient Treatment Consent Form

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in document. Please ask questions before you sign if there is anything that is unclear.

THE NATURE OF THE CHIROPRACTIC ADJUSTMENT

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," as much as you have experienced when you crack your knuckles. You may feel a sense of movement.

ANALYSIS/EXAMINATION/TREATMENT

As part of the analysis, examination, and treatment, you are consenting to any of the following procedures:

- Spinal Manipulation
- Ranges of Motion Testing
- Muscle Strength Testing
- Ultrasound
- Palpation
- Orthopedic Testing
- Postural Analysis
- Hot/Cold Therapies
- Radiographic Studies
- EMS
- Basic Neurological Testing
- Acupuncture

THE MATERIAL RISKS INHERENT IN A CHIROPRACTIC ADJUSTMENT

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulations and therapy. These may include, but are not limited to, fracture, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains, and separations. Some types of manipulations have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me. The probability of risks occurring is rare and generally results from an underlying weakness of bone. **Stroke has been the subject of tremendous disagreement. The incidence of stroke is exceedingly rare and is estimated to occur between 1 in 1 million and 1 in 5 million**. The other complications are also described as rare.

THE AVAILABILITY AND NATURE OF OTHER TREATMENT OPTIONS

Other treatment options for your condition may include self-administered, over the counter analgesics and rest, medical care and prescriptions drugs, hospitalizations or surgery. If you choose to use one of the aforementioned treatment options, you should be aware there are risks and benefits of such options and those should be discussed with your primary care giver. Remaining untreated may allow the formation of adhesions and reduction to mobility which may set up a pain reaction. Over time, this process may complicate treatment.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read the above explained and have had my questions answered by my chiropractor.

Patient Name: _____ Date: _____

Signature: _____ Doctor Signature: _____