

# THE Welcome to... SPINE WORX

Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

How did you hear about us? Give us a name!

- |  |  |
|--|--|
| <input type="checkbox"/> A Friend _____                  | <input type="checkbox"/> Drive by / saw the sign |
| <input type="checkbox"/> My Doctor _____                 | <input type="checkbox"/> Phone Book              |
| <input type="checkbox"/> My Work _____                   | <input type="checkbox"/> Radio                   |
| <input type="checkbox"/> The Spine Worx Doctors or Staff | <input type="checkbox"/> Internet                |

What is your reason for coming? \_\_\_\_\_

THERE ARE **2 SIDES** TO THIS PAGE!!! READ AND SIGN **BOTH SIDES!!!**

**Our goal:** to provide the highest quality Chiropractic care at the lowest possible fee. To do this, we have adopted specific business practices to keep your costs down. To receive care here, you must acknowledge and agree to abide by the following:

- #1 You will pay for services in full each day. Any overdraft fees will be paid immediately;
- #2 You will complete and sign a 'travel sheet' every visit. No sheet, no service;
- #3 The Spine Worx, LLC, or its doctors or staff, will NOT participate in any insurance issue in any way;
- #4 The Spine Worx, LLC, or its doctors or staff, will NOT complete any forms or paperwork (i.e. FMLA, disability, etc.);
- #5 The Spine Worx, LLC, or its doctors or staff, shall not be required to acknowledge, respond to, or fulfill any third party information requests made on your behalf, i.e. "Authorization of Release of Records" from insurance companies, doctors, lawyers, employers, and;
- #6 We will hand only YOU (or your guardian with ID) a copy of your records and X-rays at any time after the appropriate release form is completed and copy fee is paid;
- #7 ***This clinic is NOT enrolled in the Medicare program. We do not provide services to Medicare beneficiaries.*** If you have Medicare coverage, you must seek care elsewhere.

*Refusal to accept and abide by the above stated rules  
will result in dismissal from care at The Spine Worx, LLC.*

PLEASE SIGN AND DATE HERE

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
SIGNATURE DATE

**READ AND SIGN THE  
BACK OF THIS PAGE.**





## **Terms of Acceptance and Informed Consent**

**Please read and ask questions before signing.**

Here at The Spine Worx, when a patient seeks chiropractic care or acupuncture, and the patient's case is accepted, it is essential for both parties to be working toward the same objective.

At The Spine Worx, no offer is made to diagnose or treat any disease or condition other than vertebral subluxation or qi blockage. Regardless of what a disease is called, no offer is made to treat a named disease. If during the course of analysis and examination, unusual non-chiropractic / acupuncture findings are encountered, you will be advised. If you desire advice, diagnosis, or treatment for those findings, it is recommended that you seek the services of a health care provider that specializes in that area. You have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit. It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. No offer is made for the advice regarding treatment prescribed by others. Our only practice objective is to correct vertebral subluxation with chiropractic adjustments or facilitate the flow of qi with acupuncture.

**HEALTH:** A state of **optimal** physical, mental, and social well-being, **not** merely the absence of disease or infirmity.

**VERTEBRAL SUBLUXATION:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

**ADJUSTMENT:** The specific application of forces to facilitate the body's correction of vertebral subluxation. The method of correction used is by specific adjustments of the spine.

**ACUPUNCTURE:** The ancient oriental art and science of inserting *extremely* fine needles into the body to open and unblock energy or what the Chinese call *qi* to promote health. Acupuncturists may also use low voltage electrical instruments to stimulate acupuncture points. Acupuncture points are stimulated in such a way as to increase, decrease, or even redirect the flow of qi energy in the body. This is a very simple explanation for the complex process that takes place in the body during acupuncture.

**MASSAGE THERAPY:** Is the application of massage techniques on the human body and includes: (A) the use of touch, pressure, percussion, kneading, movement, positioning, nonspecific stretching, stretching within the normal anatomical range of movement, and holding, with or without the use of massage devices that mimic or enhance manual measures; and (B) the external application of heat, cold, water, ice, stones, lubricants, abrasives, and topical preparations that are not classified as prescription drugs; and does not include: spinal manipulation, diagnosis, or prescribing drugs.

As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. A rare but serious condition known as an "arterial dissection" caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache and a percentage of these patients will experience a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not and have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. The reported association between chiropractic visits and stroke is very rare and estimated to be related in one in one million to one in two million cervical adjustments.

**ATTENTION:** This facility is NOT enrolled in and does NOT participate in the Medicare program. If you are a Medicare beneficiary, you must seek care elsewhere.

By signing this form, you are stating that:

- ⇒ You have read and understand the information regarding the practice of chiropractic and acupuncture at this clinic;
- ⇒ You seek and accept care at this clinic based on the detailed information above;
- ⇒ You authorize the release of any information necessary to obtain payment for services;
- ⇒ You are financially responsible for all services rendered;
- ⇒ You verify that you are NOT a Medicare beneficiary.

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Signature of Patient, Parent, or Legal Guardian

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Date

# SPINE WORX

## GOOD FAITH ESTIMATE

PATIENT NAME: \_\_\_\_\_  
PATIENT DATE OF BIRTH: \_\_\_\_\_  
(PRINT CLEARLY!)

In compliance with 45 CFR 149.610 (the “No Surprise Act—Provision for good faith estimates of expected charges for uninsured (or self-pay) individuals”), you are being provided with a “Good Faith Estimate” (GFE) of expected charges in connection with your care at our facility today.

This is not a contract and does not require you to obtain the items or services described below. This is only an estimate regarding items or services reasonably expected to be furnished at the time the good faith estimate is issued, however the actual items, services, or charges may differ from the good faith estimate and there may be additional items or services as part of the course of care that must be scheduled or requested separately and are not reflected in this good faith estimate; You have the right to initiate a patient-provider dispute resolution process with the U.S. Department of Health and Human Services ***IF*** the actual billed charges **are \$400 or more** than the expected charges included in this Good Faith Estimate.

The Spine Worx is a CHIROPRACTIC facility and our only focus is on the detection, analysis, and correction of the **Vertebral Subluxation Complex (VSC)**. To date, there is NO diagnosis code found in the International Classification of Diseases specifically for VSC. As such, the **DIAGNOSTIC CODE** set used pertaining to this GFE are **M99.00-M99.08** (“Biomechanical lesions, not elsewhere classified”).

The services for your first evaluation include:

CPT Code	Description	Fee
99202	Problem-focused evaluation	52.00
72040, 72070, and/or 72100	Radiographic Evaluation (X-rays) consistent with your clinical presentation.	40.00
98940, 98941, or 98942	Chiropractic Adjustment consistent with your clinical presentation	20.00
<b>TOTAL COST FOR TODAY</b>		<b>112.00</b>

These services are provided by the doctors and staff of The Spine Worx located at 14 Professional Court, Lafayette, Indiana, 47905. (765) 446-0000. NPI 1548467640, EIN 26-0247483.

**In signing this document, you affirm that you have read and understand the information contained in this document.**

**Your Signature:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

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# TELL US ABOUT YOU...

Name: \_\_\_\_\_ Signature \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

## #1 Details about your problem.

**When did it start?** \_\_\_\_\_

**What caused it?**

- |                                       |  |
|---------------------------------------|--|
| <input type="checkbox"/> Overexertion | <input type="checkbox"/> Abnormal Posture    |
| <input type="checkbox"/> Car Accident | <input type="checkbox"/> Repetitive Activity |
| <input type="checkbox"/> Lifting      | <input type="checkbox"/> Fall/Slip/Trip      |
| <input type="checkbox"/> OTHER        |  |

**How does it feel?**

- |                                       |                                    |
|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Aching Pain  | <input type="checkbox"/> Sharp     |
| <input type="checkbox"/> Burning Pain | <input type="checkbox"/> Shooting  |
| <input type="checkbox"/> Cramping     | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> Dull Ache    | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Numbness     | <input type="checkbox"/> Tingling  |

**What makes it better?**

- |   |  |
|---|--|
| <input type="checkbox"/> Rest               | <input type="checkbox"/> Movement/Exercise |
| <input type="checkbox"/> Heat               | <input type="checkbox"/> Cold / Ice Packs  |
| <input type="checkbox"/> Wrapping / Support | <input type="checkbox"/> Changing Position |
| <input type="checkbox"/> Other              | <input type="checkbox"/> Nothing           |

**What makes it worse?**

- |  |  |
|--|--|
| <input type="checkbox"/> Cough/Sneeze/BM   | <input type="checkbox"/> Lift/Bend/Push/Pull |
| <input type="checkbox"/> Drive/Ride/Sit    | <input type="checkbox"/> Walk/Run/Stand      |
| <input type="checkbox"/> Changing Position | <input type="checkbox"/> Other               |

**WOMEN ONLY: Last Menstrual Period:**

**Birth Control? YES NO**

## #1 Continued

**Any Prior Treatment?**

- |   |   |
|---|---|
| <input type="checkbox"/> Medical Care/Drugs | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Surgery            | <input type="checkbox"/> Massage Therapy  |
| <input type="checkbox"/> Acupuncture        | <input type="checkbox"/> Chiropractic     |
| <input type="checkbox"/> None               |   |

**Are you taking medications?**

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Ibuprofen            | <input type="checkbox"/> Tylenol      |
| <input type="checkbox"/> Aspirin              | <input type="checkbox"/> None         |
| <input type="checkbox"/> Prescriptions (list) | <input type="checkbox"/> Herbs (list) |

**Have you had previous surgeries? Please list :**

**Please list previous serious injuries — include date, site of injury, and any treatment received.**

**Please list any chronic health care conditions (diabetes, high blood pressure, etc.)**

## #2 Have you had...? (Mark all that apply.)

- |   |   |
|---|---|
| <input type="checkbox"/> Change in bowel or bladder function recently | <input type="checkbox"/> Fever for the previous 10-14 days                |
| <input type="checkbox"/> History of cancer                            | <input type="checkbox"/> Recurrent infections                             |
| <input type="checkbox"/> Unexplained weight loss                      | <input type="checkbox"/> Inner thigh numbness or weakness of arms or legs |
| <input type="checkbox"/> Prolonged use of corticosteroids             | <input type="checkbox"/> History of stroke, TIA, or blood vessel disease  |

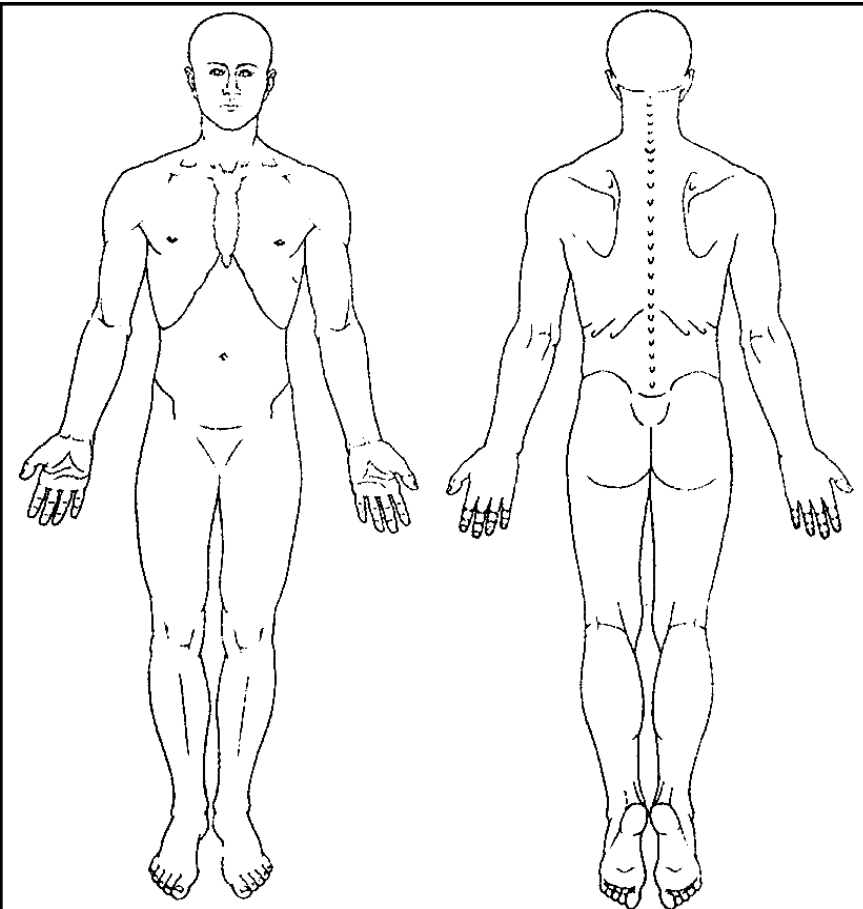
NOTES: \_\_\_\_\_

**Have you had, or do you currently suffer from any of the following problems? Please CIRCLE the ones that apply to you.**

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Fatigue, Fevers, Weight Change  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Headaches, migraines, Dizziness                                       | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Sleep disturbance   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Vision Changes  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Sinus problems, Allergies   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Adenoid, tonsil problems, Throat Problems                             | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Hearing problems  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Earaches  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Neck Pain   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Shoulder problems, Elbow Problems, Hand Problems,                     | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Thyroid disorder  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Asthma, Chronic cough, lung disorder                                  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Midback Pain  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Gallbladder problems, Anemia, Liver Problems                          | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Nausea, heartburn, Indigestion, bloating                              | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Diabetes or Hypoglycemia  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Chronic Infections, Lowered Resistance                                | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Kidney problems, Skin Disorders                                       | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Low back problems, Disc problems, Hip, leg, or foot pains             | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Bladder troubles, Urinary Problems                                    | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Menstrual Disorders, Female Problems                                  |                              |                             |
| ED, prostate problems   |                              |                             |
| Sciatica, Hemorrhoids, Cold feet, Restless legs, circulation problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Cancer, Osteoporosis  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

**INSTRUCTIONS:** Circle on the body where your problems are and use the symbols to show what type of pain you feel.

DULL / ACHE	SHARP / STAB	NUMB / COLD	BURN	TINGLE
XXXXXX	\\\\\\\\\\	- - - - -	# # #	.....



**What other health information we should know about?**

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**Printed Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_