Mt. Vernon Spine & Disc Center

Confidential Patient Information
Dr. Kent J. McMahon

4200 Williamson Place, Suite 2B
Mt. Vernon, IL 62864
P: (618) 242-8100 F: (618) 242-8101

ELECTRONIC HEALTH RECORDS/PATIENT INTAKE FORM

In compliance with requirements for the government EHR incentive program

Full Legal Name: _____ **Preferred Name**: _____

Mailing Address: _____ **City**: _____ **State**: _____ **Zip:** _____

Home Phone: _____ **Cell Phone**: _____ **Work Phone**: _____

Email address: _____

DOB: ____/____/_____ **Gender (Circle one):** Male / Female **Number of Children/Ages**: _____

Marital Status: Widowed Separated Divorced Single Married (Spouse's Name:_____)

SSN #: _____-_____-_____ **Referred by** (Friend, Relative, Physician, etc.):_____

Preferred method of contact (Circle one): Email / Phone / Mail **Preferred Language**: _____

Emergency Contact: _____ **Relationship**:_____ **Phone #**:_____

DEMOGRAPHICS– CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

EMPLOYMENT & HEALTH INSURANCE

Education level: High School Some College College Graduate Post Graduate Other:_____

Employment Status: Employed Full Time Student Part Time Student Retired Unemployed

Occupation: _____ Employer: _____

Employer Address: _____ Business Phone: _____

Primary Insurance Company: _____ ID#:_____

Group#:_____ Insured's Name:_____ Date of Birth: _____/____/_____

Secondary Insurance Company: _____ ID#:_____

Group#:_____ Insured's Name:_____ Date of Birth: _____/____/_____

Is Today's visit due to a Work Related Injury -OR- Auto Accident? Yes No ***If Yes***: Date of Injury: _____

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me.

2. I authorize my attorney and/or any insurance company to make **direct payment to you** of settlement proceeds.

3. I hereby assign and transfer to you the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your service. I authorize you to prosecute said action in my name. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance companies, whether it be all or part of what was due, **I personally owe to you**.

4. I further agree that this Authorization and Assignment is irrevocable until all moneys owed to you (Mt. Vernon Spine and Disc Center, LLC) are **paid in full**.

Signature of Patient, Parent, or Guardian X_____ Date_____

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SOCIAL HISTORY

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____ **Smoking Quit Date (Optional)**: _____

Yes No

Do you use other forms of tobacco? What/How much per day?: _____
Do you exercise? How many times per week? _____
Do you consume alcohol? How many drinks per week?:_____
Do you eat a balanced low fat diet? If no, explain: _____
Do you get adequate sleep? If no, explain: _____
Is work stressful to you? If yes, explain: _____
Is family life stressful to you? If yes, explain:_____
Do you use recreational drugs? If yes, explain:_____

HEALTH HISTORY

Primary Care Physician: _____ City: _____ State: ____ Phone: _____

May we share your information with your above listed Physician for integrated care? Yes No

Previous Chiropractic Care: Yes No *If Yes, for what Problem*: _____

Doctor/Facility Name: _____ City: _____ State: _____

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage & Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

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

2. Have you **ever** had a **stroke** or issues with **blood clotting**? Yes No *If yes, when*: _____

3. Have you recently experienced **dizziness**, unexplained **fatigue**, **weight loss**, or **blood loss**? Yes No
If yes, explain: _____

4. Have you ever had any major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries? Yes No

Date	**Injury/Fracture/Illness/Surgery**	**Treatment**	**Results**

Are you currently taking anti-coagulant or blood thinning medication? Yes No

Women only, are you currently pregnant? Yes No

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SYSTEMS REVIEW QUESTIONS:
Do you/ have you ever had problems with the following areas? (Mark **Y** for yes or **N** for no for each of the following):

1. _____Eyes
2. _____Ears, Nose, Mouth, Throat
3. _____Heart
4. _____Lungs/ Breathing
5. _____Intestines/Bowels
6. _____Urinary
7. _____ Muscles
8. _____ Nerves
9. _____ Joints/Bones
10. _____ Skin
11. _____ Internal Organs
12. _____ Blood
13. _____ Allergies
14. _____ Psychological/Emotional

Females only:

15. _____ Gynecological/Menstrual/Breast

Males Only:

16. _____ Prostate/Testicular/Penile

Please explain any above **YES** answers: _____

PAIN ASSESSMENT

Complaint(s):_____

Onset Date: _____ **Onset Was**: Gradual Sudden **Since, Has it gotten**: Worse Better

Describe what caused the pain: _____

Have you experienced your present problem before? Yes No *If yes, when*?:_____

Was treatment provided? Yes No *If yes, By whom*: _____*Outcome*:_____

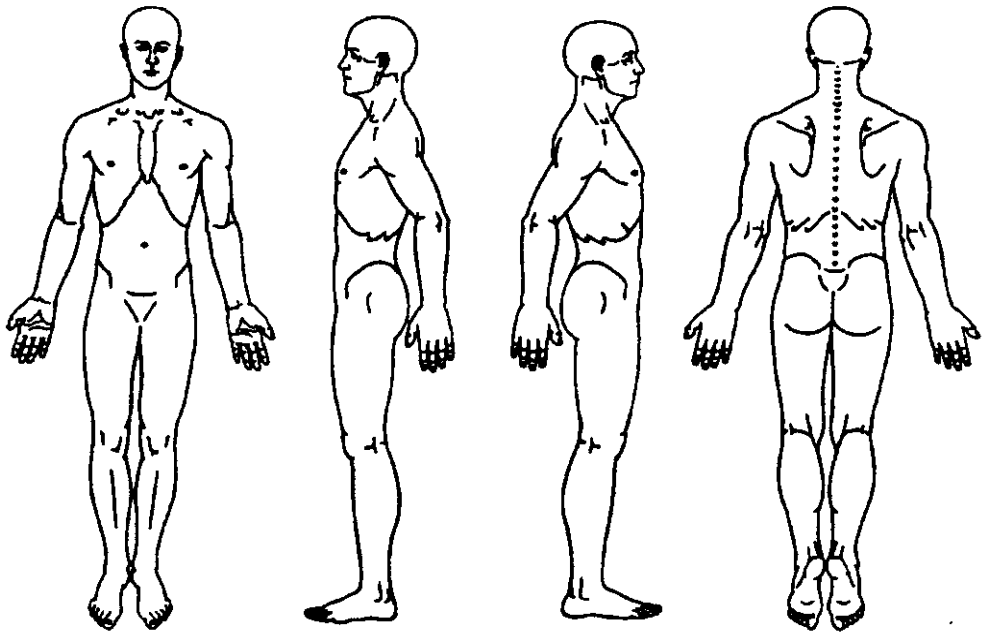
Have you tried any self-treatment or taken any medication (over the counter or prescription): Yes No

If yes, explain: _____Results:_____

PAIN CHART

Please Mark Areas of Pain using these Codes!

Symbol:	Description:
+++	**Burning**
###	**Dull/Ache**
****	**Numbness/Tingling**
===	**Throbbing**
0000	**Stabbing/Sharp**



SEVERITY OF PAIN – List region of complaint and circle which number represents intensity of pain

1. Complaint: _____ 0 1 2 3 4 5 6 7 8 9 10 (no pain — unbearable)
2. Complaint: _____ 0 1 2 3 4 5 6 7 8 9 10 (no pain — unbearable)
1. Complaint: _____ 0 1 2 3 4 5 6 7 8 9 10 (no pain — unbearable)

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INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists that perform manipulations are required by law to obtain your informed consent before starting treatment.

I _____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: There are reported cases of stroke associated with common neck movements including rotation manipulation of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between the cervical spine manipulation and the occurrence of stroke. There are reported rates of occurrence showing 1 in 1 million to 1 in 10 million will experience stroke. One in a million is about the same chance as getting hit by lightning or a normal dose of aspirin or Tylenol causing death. You are being informed of the possibility regardless of the extreme remote chance.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I acknowledge there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not a definitive science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the-counter medications, exercises, and/or possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include an unsuccessful outcome, post-surgical complications, pain or reaction to anesthesia, and/or prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and/or worsening pathology. The aforementioned may complicate current or future treatment, making recovery and rehabilitation more strenuous and prolonged.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ Signature of Patient, Parent, or Guardian Date_____

_____Signature of Witness Date_____

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FINANCIAL/PRIVACY POLICY AND DISCLAIMER

INSURANCE VERIFICATION

Insurance verification is not a guarantee of payment. Verification is only a quote of patient benefits. We bill insurance as a courtesy to our patients; it is patient responsibility to ensure there is benefit coverage. **Any charges not covered by insurance are the patient's responsibility and due within 30 days of billing.**

COLLECTION OF PATIENT BALANCE

It is our policy to collect at time of service. Once we receive an "Explanation of Benefits" report from the patient's insurance company, we will then bill or credit the account for the remaining balance. Reimbursement checks can be issued upon request, if warranted.

If any "Explanation of Benefits" show the patient has an outstanding responsibility for any reason, the patient will receive a bill outlining the outstanding charges. **Payment is due within 30 days** of receipt of the bill.

In the event a bill is disputed, you must notify us within 30 days. If you do not notify us within that time, the bill will be presumed valid and due. All balances remaining unpaid after 30 days will accrue **interest at the rate of 18% per annum**. In the event any further action is necessary to collect an unpaid bill, you will be responsible for all attorney's fees and court costs incurred by us.

All balances remaining **unpaid after 30 days may be reported to a third-party credit bureau**, at our discretion, and may affect your credit rating.

Worker's Compensation (On-the-Job Injury)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance policy. Your employer MUST PRE-AUTHORIZE your care. You will need to inform your employer of the accident and obtain the contact information of their health insurance provider, as well as any claim number assigned to your case. If your employer does not provide us with this information, or if a settlement has not been made within three months of treatment, or you suspend or terminate care for any reason, any fees for services are due immediately and can be turned over to a third-party credit bureau if unpaid.

Notify us immediately if your claim is disputed and if an attorney will be representing you.

Personal Injury or Automobile Accidents

Please notify your auto insurance carrier of your visits to our office immediately. Notify us immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for the settlement of your claim up to six 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 only service covered by Medicare for chiropractors is the 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% as well as any fees for non-covered services. Our office completes and files the forms for Medicare at no charge.

If you have a secondary policy, it may or may not cover your Medicare deductible and the remaining 20% of the manipulation.

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RETURNED CHECKS

It is our policy to collect **$25.00 for checks that are returned to us**. This is to cover any fees that apply from the transaction.

APPOINTMENTS

If unable to keep an appointment, as a courtesy to our staff and other patients please give 24-hour notice. If it is a continual problem there will be a **$20 charge** added towards your account each visit that is missed. The patient will be responsible for payment.

FINANCIAL POLICY QUESTIONS

We are happy to address questions regarding your account at any time. Please direct accounting questions to our office manager, Lisa Hicks.

HIPAA PRIVACY POLICY

Attached to the patient information packet at the back of these forms is the HIPAA Notice of Privacy Practices Policy for you**.**

The patient has read and understands the payment policy of Mt. Vernon Spine and Disc Center, LLC. The patient understands that the insurance is an arrangement between the patient and their insurance company. It is NOT between Mt. Vernon Spine and Disc Center, LLC and their insurance company. The patient requests Mt. Vernon Spine and Disc Center, LLC to prepare the customary forms so that he/she may obtain benefits. The patient also understands that if their insurance company does not respond within 90 days, or he/she suspends or terminates care, all fees are due and payable immediately.

By signing below, the patient acknowledges that he/she has received the HIPAA Privacy Policy and that he/she understands and will comply with our financial policies.

_____ Signature of Patient, Parent, or Guardian Date_____

_____ Signature of Witness Date_____

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Notice of Information Practices and Privacy Statement

For Mt. Vernon Spine and Disc Center, LLC
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How We Collect Information About You: Mt. Vernon Spine and Disc Center, LLC (MVSDC) and its employees and volunteers collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

What We Do Not Do With Your Information: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between MVSDC and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, insurance, etc.

If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Information We Do Not Collect: We do not use cookies on our website to collect data from our site visitors. We do use some affiliate programs that may or may not capture traffic data through our site.

Limited Right to Use Non-Identifying Personal Information from Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of MVSDC. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.