Confidential Patient Information

Triangle CRC, PLLC
2011 Falls Valley Dr. Suite 102
Raleigh, NC 27615

(919) 792-8682 Phone
(919) 882-1774 Fax
www.TriangleCRC.com

Date:_____/_____/_____

Patient's Full Name _____

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

Cell Phone: _____-_____-_____ Additional Phone: _____-_____-_____ E-Mail:_____

Patient's Weight:_____ Patient's Height:_____

☐ Male ☐ Female Date of Birth:_____/____/_____ ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Spouse's Name:_____ Number of Children/Ages_____

_____

Who can we thank for your referral? _____

If no direct referral, how did you find us?_____

Social Security # _____ - _____ - _____

Status: ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Homemaker ☐ Unemployed

Occupation:_____ Employer:_____

Emergency Contact:_____ Relationship:_____ Phone: _____

Family Physician: _____ City: _____ State:_____ Phone_____

Previous Chiropractic Care: ☐ Yes ☐ No Chiropractor's Name/Location _____

Authorization of Release

In consideration of your undertaking to care for me, I agree to the following: Triangle Chiropractic and Rehabilitation Center, PLLC, and its physicians and staff are authorized to release **any information** deemed 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. I understand that I acknowledge that my health-related information may be shared with other providers for my benefit and fully authorize TriangleCRC and its physicians and staff to **release and/or be the recipient of** information as necessary; this includes, but is not limited to: diagnostic imaging, patient records, procedures, surgical reports, and/or any pertinent health-related information.

Patient Signature:_____ **Date:**_____/_____/_____

Payment/Insurance Information

Who is responsible for your bill? ☐ Self Pay ☐ Personal Health Insurance Carrier: _____

Insurance Card ID Number: _____ Group # _____

Policy Holder's Name: _____ Policy Holder's Birth Date:_____

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Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Are you pregnant? ☐ Yes ☐ No # Weeks _____ Estimated Due Date: _____ # of Pregnancies _____
# of Vaginal Births _____ # of Cesarean Births _____ Names and Ages of Children _____
Brief Birth History
_____
_____

If pregnant: Birth Team
Midwife: _____OB/GYN: _____
Doula:_____ Other: _____
Where will you be birthing your baby?
Hospital_____ Home_____ Birthing Center_____ Other_____
Have you taken, or do you plan to take, any childbirth education classes?
_____

Are you less than two years postpartum? ☐ Yes ☐ No

Your postpartum recovery: ☐ Has been amazing. ☐ Is a work in progress. ☐ Needs improvement. ☐ I've had none.

Please fill out the symptom chart below, OR select one of the following reasons for your visit:

☐ Pregnancy Care ☐ Diastasis Rectus Abdominis ☐ Pelvic Floor Dysfunction ☐ Wellness

Complaint #1

Present complaint(s):_____
When did your symptoms begin? (Specific date if possible) _____
How did your symptoms begin? (i.e. Lifting, etc.) _____
In the past have you had anything similar to this? ☐ Yes ☐ No Please explain_____
_____

DESCRIBE YOUR SYMPTOMS

#1 Complaint _____

(Rate your level of Pain, Scale 0-10)

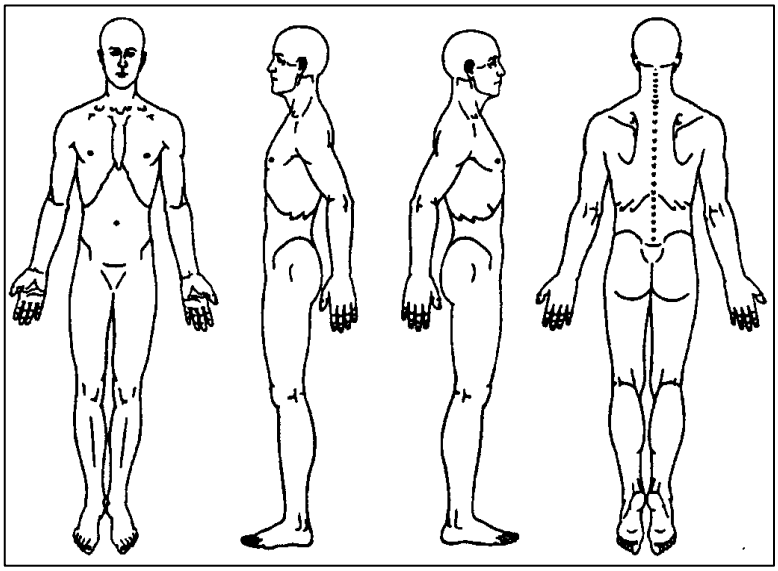
0 1 2 3 4 5 6 7 8 9 10
No pain Unbearable

Check all that apply to your #1 Complaint

☐ Sharp	☐ Ache	☐ Tingling
☐ Stabbing	☐ Soreness	☐ Numbness
☐ Burning	☐ Weakness	☐ Dull
☐ Shooting	☐ Throbbing	☐ Constricting

☐ Other_____

How often are your complaints present?
☐ Constant 100% of the time ☐ Frequently 75%
☐ Intermittent 50% ☐ Occasional 25%



Are your symptoms:
☐ Increasing
☐ Decreasing
☐ Not Changing
☐ Varies

Symptoms began:
☐ Suddenly
☐ Gradually

Symptoms present:
☐ AM
☐ PM
☐ All day

Pain is aggravated by:

☐ Walking	☐ Lifting
☐ Sitting	☐ Bending
☐ Riding in a car	☐ Stretching
☐ Standing	☐ Twisting

☐ Other_____

Pain is improved by:

☐ Medication	☐ Chiropractic Adjustment
☐ Rest	☐ Ice
☐ Exercise	☐ Heat
☐ Therapy	☐ Nothing so far

☐ Other_____

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Complaint #2:

Present complaint(s):_____

When did your symptoms begin? (Specific date if possible) _____

How did your symptoms begin? (i.e. Lifting, etc.) _____

In the past have you had anything similar to this? ☐ Yes ☐ No Please explain_____

_____

DESCRIBE YOUR SYMPTOMS

#2 Complaint _____

(Rate your level of Pain, Scale 0-10)

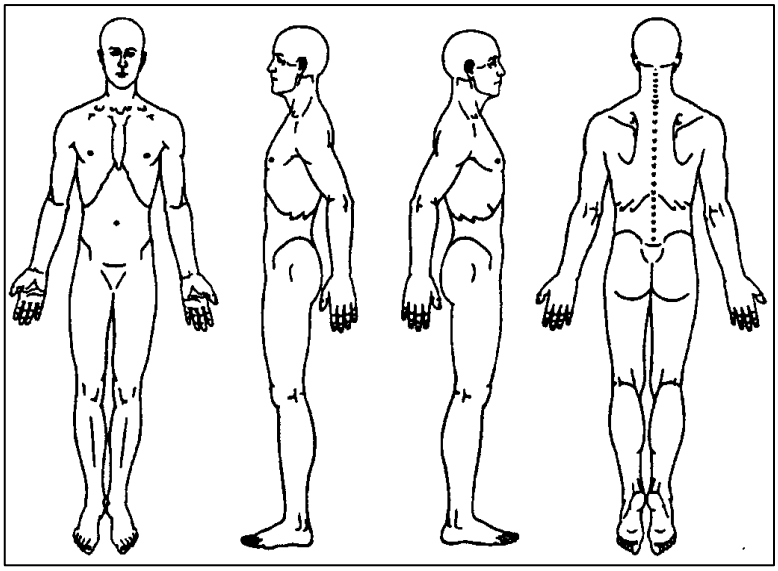
0 1 2 3 4 5 6 7 8 9 10
No pain Unbearable

Check all that apply to your #2 Complaint

☐ Sharp	☐ Ache	☐ Tingling
☐ Stabbing	☐ Soreness	☐ Numbness
☐ Burning	☐ Weakness	☐ Dull
☐ Shooting	☐ Throbbing	☐ Constricting

☐ Other_____

How often are your complaints present?
☐ Constant 100% of the time ☐ Frequently 75%
☐ Intermittent 50% ☐ Occasional 25%



Are your symptoms:
- ☐ Increasing
- ☐ Decreasing
- ☐ Not Changing
- ☐ Varies

Symptoms began:
- ☐ Suddenly
- ☐ Gradually

Symptoms present:
- ☐ AM
- ☐ PM
- ☐ All day

Pain is aggravated by:

☐ Walking	☐ Lifting
☐ Sitting	☐ Bending
☐ Riding in a car	☐ Stretching
☐ Standing	☐ Twisting

☐ Other_____

Pain is improved by:

☐ Medication	☐ Chiropractic Adjustment
☐ Rest	☐ Ice
☐ Exercise	☐ Heat
☐ Therapy	☐ Nothing so far

☐ Other_____

☐ Yes ☐ No Is pain affecting your ability to work or be active? If Yes explain:_____

☐ Yes ☐ No Any change in bowel/bladder function, including stress incontinence? If Yes explain:_____

☐ Yes ☐ No Any fever or chills? If Yes explain:_____

☐ Yes ☐ No Any dizziness associated with symptoms? If Yes explain:_____

☐ Yes ☐ No Have you experienced any unexplained weight loss, fatigue, or blood loss? If Yes explain:_____

☐ Yes ☐ No Are your complaints affecting your sleep? If Yes explain:_____

☐ Yes ☐ No Have you had any tests for this complaint? (i.e. x-rays, MRI, CT) If Yes explain:_____

☐ Yes ☐ No Any recent falls / accidents / surgeries / broken bones? If Yes explain:_____

☐ Yes ☐ No Have you seen any other physicians in the past 6 months? If Yes explain:_____

☐ Yes ☐ No Have you had any prior treatment, including any physical therapy? If Yes, what treatment?_____

☐ Yes ☐ No Have you been in the hospital or had surgery for any reason? If Yes explain:_____

☐ Yes ☐ No Have you ever been in an accident? If Yes explain:_____

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☐ Yes ☐ No Do you smoke? If Yes how much?:_____
If you have quit smoking, when did you quit?_____
☐ Yes ☐ No Do you consume alcohol more than socially?
☐ Yes ☐ No Do you exercise? If Yes what is your routine?_____

What **non-prescription** medication are you taking?

☐ Tylenol ☐ Aspirin
☐ Ibuprofen ☐ None
☐ Other_____

How often?
☐Daily ☐Weekly ☐Other:_____

What **Prescription** medication are you taking?

☐ Anti-inflammatory ☐ Birth Control Pill ☐ Nerve Pills
☐ Pain Killers ☐ Cholesterol Meds ☐ HRT
☐ Muscle Relaxers ☐ Insulin ☐ Sleeping Aid
☐ Blood Pressure Meds ☐ Thyroid Meds ☐ Recent Antibiotics
☐ Other_____ ☐ None
Specific names if possible:_____

Do you experience any of the following:

☐ Stress urinary incontinence ☐ Hemorrhoids
☐ Urge incontinence ☐ Lack of orgasm
☐ Overactive bladder ☐ Painful intercourse
☐ Bowel Incontinence

If the answer to any of the following questions is yes, please elaborate as you feel comfortable. We will discuss these topics, and you need not fill out information that you do not wish to divulge.

Have you ever experienced sexual trauma or been the victim of sexual abuse? _____
Have you experienced a miscarriage, infant loss, or abortion? _____

Please circle regular dietary intake: fruits vegetables meats grains dairy products nuts/seeds/berries sugars Paleo/Primal gluten-free vegetarian Vegan

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses below:

☐ Childhood Trauma ☐ Financial stress
☐ Loss of loved one ☐ Work/School stress
☐ Abuse ☐ Significant illness
☐ Divorce/Separation ☐ Major lifestyle change

How do you grade your physical health? (A= Great, B= Good, C= Needs Improvement, D= Nowhere to Go But Up)
☐ A
☐ B
☐ C
☐ D

How do you grade your emotional health?
☐ A
☐ B
☐ C
☐ D

How do you rate your overall "quality of life"?
☐ A
☐ B
☐ C
☐ D

Who else is on your healthcare team? Would you like us to keep in touch with them regarding your care? ☐ Yes ☐ No

_____

What type of care are you interested in: ☐ Pain relief only ☐ Healing of current condition ☐ Optimizing your health ☐ All three
Pertinent family health history: list any diseases, disorders, or major illnesses _____
Other health concerns?_____

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INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation 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: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as get-ting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

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 appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact 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 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 unsuccessful outcome, complications, pain or reaction to anesthesia, and 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 worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

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:_____ Date:_____

Signature of Parent or Guardian:_____ Date:_____

Signature of Witness(if a minor):_____ Date:_____

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Please note: your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Our office uses an online software program to **estimate** what you will owe, but *charges are not guaranteed or finalized until claims have been filed and your insurance company reviews your claim*. This process typically takes 30-90 days. Most insurance plans limit the number of times they will pay for you to see certain practitioners per year. It is the patient's responsibility to ensure they do not go over their insurer's annual visit limit. Once your visit limit has been reached, you will be responsible for the full cost of each additional visit.

We are not responsible for your insurer's final payment and benefit determinations.

In order to help you determine your responsibility toward payment for services, please read the following and initial your preference for the method of payment for your account. Please notify this office if the status of your insurance changes.

Private pay: (please initial)
A_____As I have no insurance coverage for the services provided, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.
B_____I have insurance coverage, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.
C_____I have insurance coverage, but wish to opt out of using any benefits I may have. I will not file claims on my behalf and understand TCRC will not be filing my claims.

Health Insurance: (please initial)
D_____I would like this clinic to bill my insurance. I understand that my insurance company's payment is not guaranteed to align with this office's estimate, and that I am responsible for payment in full according to my insurance company's final decision.

Missed appointments:
It is the policy of Triangle Chiropractic & Rehabilitation Center, PLLC to assess a $37.50 missed visit fee to patients who cancel appointments with less than a 24 hour notice. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care to others.

_____My initials here indicate that I understand the above missed visit policy.

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand that if payment is not rendered at the time of service, I am expected to remit payment within 30 days of service*. All balances after 30 days will be charged to my credit care on file. If payment is unsuccessful, charges may be turned over to a collection agency. I understand and agree to conditions of this policy.

*If you are having trouble paying your bill, arrangements may be made for payment plans upon request. You will still be responsible for payment in full.

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. 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.

Designation of Authorized Representative
I do hereby designate TriangleCRC to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I receive from TriangleCRC. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, health care benefit plan reimbursement and to pursue any other applicable remedies.

IRREVOCABLE Power of Attorney
I do hereby authorize Triangle Chiropractic and Rehabilitation Center to act on my behalf to pursue claims and exercise all rights in order to collect payments with respect to any medical or other health care expense(s) incurred as a result of the services I receive from TriangleCRC.

Patient's Printed Name:_____

Patient/Guardian Signature:_____Date:_____/_____/_____