Murray Chiropractic Center

2100 Kansas Ave. Great Bend, Kansas 67530

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance card. All information you supply is confidential.

Today's Date ______ First Name ______ Middle Initial ______ Last Name ______ Preferred First Name ______ Age ______

Address ______ City ______ State ______ Zip ______ Birth Date (MM/DD/YY) ______

Home Phone ______ Cell Phone ______ Cell Phone Carrier ______ Social Security Number ______ __M __F *Gender*

Spouse's Name ______ Number of Children ______ ___Married ___Single ___Divorced ___Widowed *Marital Status*

Primary Care Provider/Office Name ______ *Who may we thank for your referral?/How did you find us?* ______

Email ______ Emergency Contact Name and Phone Number ______

If under 19 - Parent/Guardian ______ __Full Time __Part Time *Student* Primary Care Provider/Office Name ______

Your Occupation ______ Your Employer and Work Address ______ Work Phone ______

Have you had chiropractic care before? ______ If so, from whom and when? ______

Please describe symptoms that you are having below. **Rate pain 0 (none) to 10 (agonizing)**

(pain, tension, muscle aches, headaches, etc.) Pain (Rate 0-10) at:	WORST	BEST	NOW	AVERAGE
Neck ______	___	___	___	___
Mid Back ______	___	___	___	___
Low Back ______	___	___	___	___
Sacroiliac Joints/Other ______	___	___	___	___

When did you first notice the symptom(s)? ____________________

How did the symptom(s) begin? __Work Related __Auto Accident __Injury __Other__________

How often do you feel the symptom(s)? __constant __nearly constant __50% __25% __under 25%

When do you feel the symptom(s) more? __lying down __walking __sitting __standing __bending __rising up __lifting __morning __afternoon __evening __night __other__________

Do you feel the pain radiate to other areas? Where?____________________

Have you tried anything to relieve the symptom(s)? __Prescription drugs __Over the counter drugs __Surgery __Physical Therapy __Massage __ Chiropractic Care __Other__________

Does anything make the symptom(s) better? (sitting, ibuprofen, etc.)____________________

Does anything aggravate the symptom(s)?(activities, movements, etc.)____________________

What do the symptoms feel like? (Check all that apply.) __numb __tingling __stiff __dull __ache __sharp __cramp __burn __shooting __stabbing __throbbing __other__________

Please check any illnesses that you've *had* in the past or currently *have* below.

Musculoskeletal and Neurological Problems

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
____	____	Osteoporosis	____	____	Arthritis	____	____	Scoliosis	____	____	Neck Pain
____	____	Back Pain	____	____	TMJ Pain	____	____	Joint Pain	____	____	Depression
____	____	Anxiety	____	____	Headache	____	____	Dizziness	____	____	Numbness
____	____	Tingling	____	____	Migraine	____	____	Other__________			

Cardiovascular and Respiratory Problems

HAD	HAVE		HAD	HAVE		HAD	HAVE	
____	____	High/Low Blood Pressure	____	____	High Cholesterol	____	____	Poor Circulation
____	____	Angina	____	____	Excessive Bruising	____	____	Racing Pulse
____	____	Heart Attack	____	____	Pacemaker	____	____	Emphysema
____	____	Pneumonia	____	____	Asthma	____	____	Apnea
____	____	Seasonal Allergies	____	____	Shortness of Breath	____	____	Other ________

Digestive and Endocrine Problems

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
____	____	Anorexia	____	____	Bulimia	____	____	Ulcer	____	____	Food Allergies
____	____	Heartburn	____	____	Constipation	____	____	Diarrhea	____	____	Hypoglycemia
____	____	Infections	____	____	Low Energy	____	____	Swollen Glands			
____	____	Hypothyroid	____	____	Hyperthyroid	____	____	Other __________			

Sensory and Skin Problems

HAD	HAVE		HAD	HAVE		HAD	HAVE	
___	___	Blurred Vision	___	___	Ringing in Ears	___	___	Hearing Loss
___	___	Chronic Ear Infection	___	___	Loss of smell or taste	___	___	Acne
___	___	Skin Cancer	___	___	Psoriasis	___	___	Eczema
___	___	Hair Loss	___	___	Rash	___	___	Other

Genitourinary Problems

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
___	___	Kidney Stones	___	___	Infertility	___	___	PMS	___	___	Erectile Dys.
___	___	Bedwetting	___	___	Prostate Issues				___	___	Other

Constitutional Problems/Illnesses/Injuries

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
___	___	Weight Change	___	___	Low libido	___	___	Fainting	___	___	Poor appetite
___	___	Weakness	___	___	Fatigue	___	___	HIV	___	___	Alcoholism
___	___	Allergies	___	___	Cancer	___	___	Chicken Pox			
___	___	Diabetes	___	___	Eczema	___	___	COPD	___	___	Epilepsy
___	___	Glaucoma	___	___	Goiter	___	___	Gout	___	___	Heart Disease
___	___	M.S.	___	___	Malaria	___	___	Measles	___	___	Hepatitis
___	___	Rheumatic Fever	___	___	Mumps	___	___	Polio	___	___	Pneumonia
___	___	Scarlet Fever	___	___	STD	___	___	Stroke	___	___	Tuberculosis
___	___	Typhoid	___	___	Ulcer	___	___	Other___			

___ ___Persistent cough, night sweats or fever for 2 weeks or spitting up bloody sputum

___ ___Fractures or dislocations(*please list*)___

___ ___*Please list any other problems or illnesses*___

Please list all medications and over the counter products, including vitamins, that you take.___

___

___

Please list any surgeries you have had and approximate dates.

___

___

Social History

Alcohol Use __daily __weekly How much?___

Coffee Use __daily __weekly How much?___

Tobacco Use __daily __weekly How much?___

Soft Drinks __daily __weekly How much?___

*Pain Relievers*__daily __weekly How much?___

Prayer or meditation? __yes __no

Vaccinated? __yes __no

Mercury fillings? __yes __no

Recreational drugs __yes __no

Exercise __yes __no How often and what type?___

Family History

Relative	*Age if living*	*State of health*	*Illnesses*	*Age at death*	*Cause of death*
Mother	________	__good __fair __poor	____________	________	________
Father	________	__good __fair __poor	____________	________	________
Sister 1	________	__good __fair __poor	____________	________	________
Sister 2	________	__good __fair __poor	____________	________	________
Brother 1	________	__good __fair __poor	____________	________	________
Brother2	________	__good __fair __poor	____________	________	________
________	________	__good __fair __poor	____________	________	________

Are there any other hereditary issues you are aware of?____________________________

Activities of Daily Living *Please circle any activities that are affected by your pain/symptoms.*

Sitting	Grocery Shopping	Rising Up	Household Chores
Standing	Lifting Objects	Walking	Reaching Overhead
Lying Down	Bathing or Showering	Bending Over	Dressing
Falling Asleep	Staying Asleep	Computer Use	Personal Relationships
Using Stairs	Getting in/out of Car	Driving Car	Concentrating on Tasks
Exercising	Looking over Shoulder	Yard Work	Caring for Family
Working your Job	Other (please describe)________________________		

- -

What are your major stressors?____

How do you sleep? __side __back __stomach   Average sleep per night?______________hours

What are your typical eating habits? __skip breakfast __2 meals/day __3 meals/day __snacks

In addition to the reason(s) for your visit today, what additional health goals do you have?________

____

Acknowledgments

To set clear expectations and improve communication, please read each statement and initial your agreement.

*Initials*_____ I instruct the chiropractor to deliver care that, in his or her professional judgment, can best help me in the restoration of my health. I understand that chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. I understand that Chiropractic is a separate and distinct healing art and does not proclaim to cure any disease. I have read and understand the "*Available Treatment and Risks*" form.

*Initials*_____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third party. I have read and agree to the "*Consent for Purposes of Treatment, Payment, and Health Care Operations*" form.

*Initials*_____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. (Females: Date of last menstrual period_____________________)

*Initials*_____ I grant permission to be called to confirm or reschedule an appointment and to be sent text reminders, other texts, cards, letters, emails, or health information to me as an extension of my care in this office.

*Initials*_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive. I have read and agree to the "*Direct Assignment of Benefits and Authorization to Release Information*" form.

*Initials*_____ I understand that if I am a Medicare patient that Medicare only pays for adjustments of the spine and only if certain conditions have been met. I have read and understand the "Medicare Guidelines for Chiropractic" form and agree to it.

*Initials*_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern(s).

_______________________________________ _______________________

Signature Date (MM/DD/YYYY

____

If the patient is a minor child, print child's full name.

____

Staff Signature

____

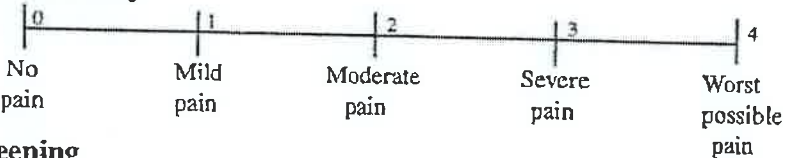
Doctor Signature

Functional Rating Index

For use with Neck and/or Back Problems only.

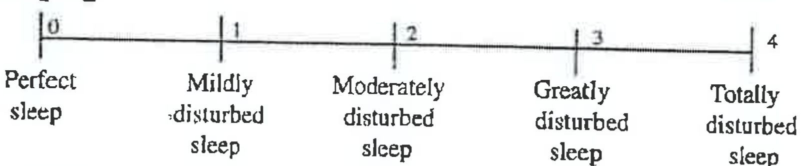
In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity



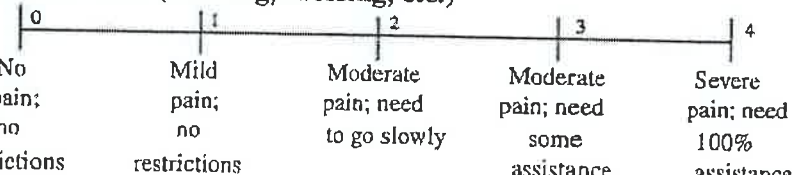
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping



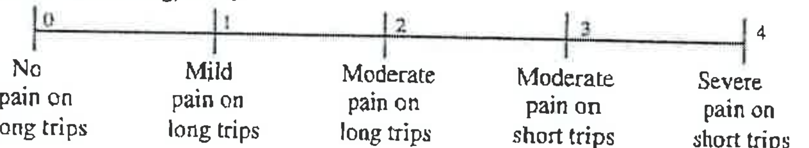
0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

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



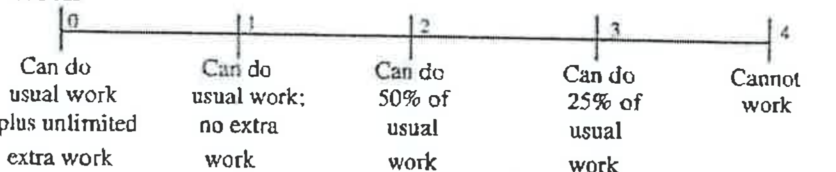
0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)



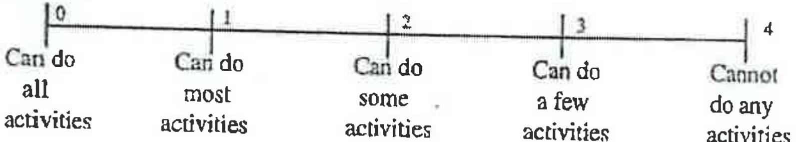
0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work



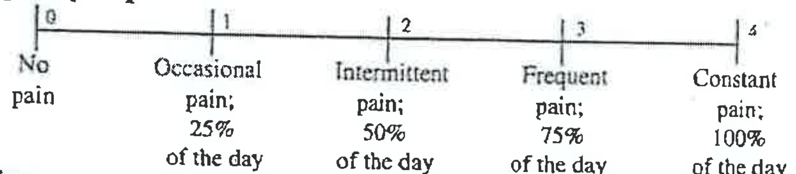
0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation



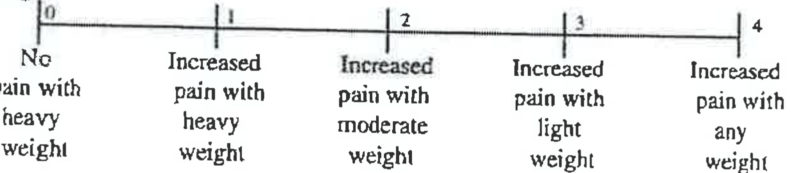
0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain



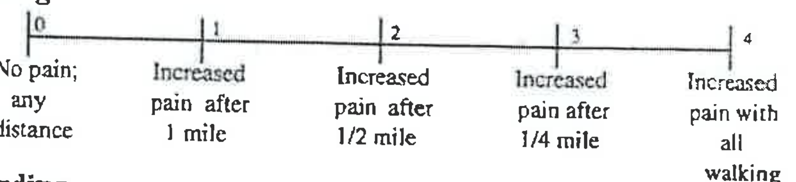
0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting



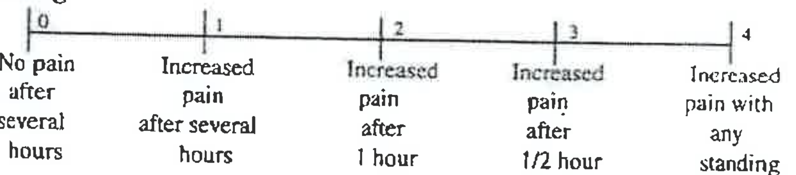
0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

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 ______________________
PRINTED

____
Signature

____
Date

Total Score __________

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www.chiroevidence.com

2100 Kansas Ave – Great Bend, KS 67530 - (620) 792-1386

Notice of Privacy Practices Signature Page

To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the Practice's Privacy Officer as follows:

Name: Daniel L. Murray Jr., D.C. - Privacy Officer

Address: 2100 Kansas Ave - Great Bend KS, 67530

Telephone No.: (620) 792-1386

We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. The Practice reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, and any information we create or receive in the future. We will distribute any revised Notice to you prior to implementation.

I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient: ______________________________ Date: ____________________

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DOT PHYSICALS

DOT Physicals are a cash service and either you or your company are expected to pay at the time of service unless prior arrangements have been made with your employer. We have arrangements for billing with many companies for their employee physicals. We do NOT bill insurance for DOT Physicals.

GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and Murray Chiropractic Center. As a courtesy to our patients, our office will complete and file necessary forms with your primary insurance carrier to help you collect. You are responsible for letting us know when your Explanation of Benefits for each visit has come back from your primary insurance carrier if you have a secondary carrier that you need billed as well.

You understand and agree that services rendered are ultimately your financial responsibility. You are responsible for deductibles, copays, co-insurance and any amounts that insurance does not pay for any reason. If you make overpayment, we can refund you or overages can be kept on your account for up to 90 days for future visits. Items such as decompression, nutrition, Biofreeze, ice packs and kinesiotape are not covered by insurance and are expected to be paid for in full at the time of purchase.

If you have a large deductible that has not been met, you will be expected to pay for all services in full at the time they are performed. Please keep in mind that we cannot guarantee that your insurance will pay and some policies either have no coverage or very limited coverage for chiropractic.

Depending on your insurance company, we may be considered "in-network" or "out-of-network". We will do our best to keep you apprised of the status, but you are responsible for anything insurance doesn't cover whether we are in or out of network. If we are not in-network with your insurance company, we will bill your insurance company, but you are expected to pay in full for services at the time they are performed.

PATIENTS WITHOUT INSURANCE

All services are expected to be paid for in full at the time of service. If other temporary arrangements need to be made, please discuss this with our office manager. All nutrition and other physical items must be paid for in full at the time of purchase.

ON THE JOB INJURY

We do not accept Worker's Compensation cases. If you have been injured at work and wish to be seen, you will be expected to pay for services as they are rendered and it will NOT be billed to your personal health insurance.

PERSONAL INJURY OR AUTO ACCIDENT

We accept these types of cases only in current patients on a case-by-case basis. Please present your auto insurance information immediately. You are personally responsible for your bill, but we will wait for payment from the auto carrier as long as you are an active patient. This will NOT be billed to personal health insurance.

MEDICARE

We accept assignment from Medicare, but they will only cover active care adjustments of the spine. They do NOT cover required exams and re-exams, therapies, extraspinal adjustments or maintenance care. Once the Medicare deductible is met, Medicare will pay 80% of approved adjustments. The patient is responsible for payment in full on all services that go towards deductible, for their 20% co-insurance and for all non-covered services. Payment on non-covered services are due the day they are rendered. If you have a secondary policy, please let us know. If the secondary policy is an automatic cross-over policy, Medicare will file for you. If it is not, you are responsible for filing and we can provide the necessary forms.

THINGS YOU SHOULD DO TO HELP US FILE YOUR INSURANCE

1. Present your driver's license or state I.D., insurance and/or Medicare card to be copied and kept in your file.
2. Our office policy is that any non-covered service, co-pay or deductible must be paid as services are rendered. Please be prepared to do so.
3. If you change insurance policies, insurance companies or become eligible for Medicare, please notify us immediately so that we can update your file to send claims to the correct place.
4. You are asked to authorize Murray Chiropractic Center to furnish information regarding your case to your insurance company and to assign all benefits as a result of this claim. This permits us to follow up if benefits are other than anticipated and to keep up with any developments with your insurance company.

I agree to abide by the policies stated on this form.

*Signature:*________________________________ *Date:*________________

MURRAY
CHIROPRACTIC CENTER

Danny Murray, D.C.
Sclie Murray, D.C.
2100 Kansas Avenue
Great Bend, KS 67530
620-792-1386 • 800-847-3363
Fax: 620-792-8634

NOTICE OF MEDICARE COVERAGE FOR CHIROPRACTIC CARE

Your Medicare coverage of chiropractic care is limited. It does not pay for all services. It will only pay for your chiropractic adjustment (manipulative treatment) when it meets Medicare's specific rules. There are three categories of Medicare services: 1) non-covered 2) always-covered, and 3) perhaps-covered.

NON-COVERED SERVICES

According to existing Medicare law, most of the services in our office are NON-COVERED. Hopefully, the U.S. Congress will change that someday and treat Doctors of Chiropractic like all other doctors. Until then, here is a summary:

Examples of Non-Covered Services

All Services Other than Chiropractic Adjustments:

- Office Visits - to evaluate and manage, re-evaluate, advise, or give counsel regarding your health.
- Physiotherapy - such as massage, traction, electrical stimulation, neuromuscular re-education, etc.
- X-rays, Laboratory, Supplies, Vitamins, etc.

Various Chiropractic Adjustments or Treatments:

- Non-spinal manipulation to the shoulder, arm, leg, etc.
- Maintenance Care - you are stable and not making any more improvement.
- Wellness Care - to promote better health.

ALWAYS-COVERED SERVICES

A Medicare COVERED service is for when you are injured or when you are in pain due to a bad spinal condition. Medicare pays for your rehabilitation as long as you are improving. This phase of care is call "active treatment." It will be shown on your Medicare claim form and payment reports with your service code. For example, "98940-AT."

PERHAPS-COVERED SERVICES

Your Chiropractic Adjustment must be clinically needed to correct a problem of the spine, according to Medicare rules. If Medicare determines that your condition is not "Medically Necessary" they will not pay. When we know or believe that your chiropractic adjustment is no longer covered, we will discuss this matter with you. We will also give you a Medicare form known as the Advance Beneficiary Notice (ABN) which will show your financial obligation for continued care.

MY FINANCIAL RESPONSIBILITY

I have received the above Medicare information. I understand that I am personally **financially responsible** for all services not covered by Medicare. I am also responsible for applicable annual deductibles or copayments.

x ______________________________ ______________
Signature of patient or person acting on patient's behalf Date

MY AUTHORIZATION

I authorize the **release** of any medical or other information necessary to process my claims. I also **request** payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

x ______________________________ ______________
Signature of patient or person acting on patient's behalf Date

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to a payer, your health information on this form may be shared with the payer. Your health information which the payer sees will be kept confidential by the payer.

www.murraychiropracticcenter.com • murraychiropracticcenter@yahoo.com

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