

Westcott Chiropractic Center

"Your Spine Is The Key To Good Health"
29671 Six Mile Rd. Ste 110C, Livonia, Mi 48152
(734)427-1579
Dr. Jennifer L. Westcott

Patient Intake

Today's Date _____

Name _____ Age _____ Date of Birth ____/____/____

Address _____ City _____ St _____ Zip _____

Marital Status: Single Married Other Sex _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Email Address _____

Employer _____ Occupation _____

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

Spouse Information

Name _____ Date of Birth ____/____/____

Cell Phone(____) _____ Work Phone(____) _____

Emergency Contact

Name _____ Relationship to Patient _____

Contact Home Phone(____) _____ Cell Phone(____) _____

How Did You Hear About Our Office? _____

Accident Information (SKIP this Section if you were not involved in an accident)

Is your condition due to an **Auto Injury Work Injury Slip and Fall Other Accident (describe below)**

Date of Accident _____ Place (City/State) _____

Insurance _____ Address _____

City _____ St _____ ZipCode _____ Phone _____

Contact Person _____ Claim# _____

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Patient Assessment

Primary reasons for seeking chiropractic care:

Primary reason _____

Secondary reason _____

Chief Complaint:

Location of Complaint _____

Complaint Began When and How _____

Please Circle the Quality of the complaint/Pain **Dull Aching Sharp Shooting Burning**
Throbbing Deep Nagging Other _____

Does this complaint/pain radiate or travel(shoot) to any area of your body? Where? _____

Do you have numbness or tingling in your body? Where? _____

How frequent is complaint present, how long does it last? _____

Does anything aggravate or make the complaint better? _____

Rate your pain

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

Previous interventions, treatments, medications, surgery, or care you have sought for your current complaint _____

How Often do you experience your symptoms?

Constantly
(76-100% of the day)

Frequently
(51-75% of the day)

Occasionally
(26-50% of the day)

Intermittently
(0-25% of the day)

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Patient Past Health History

What accidents, falls, injuries have you had in the past?(This includes old injuries, contact sports, etc...) Please include the date _____

Have you broken any bones? Which Ones? How/When? _____

Have you ever had chiropractic care? If yes, last date of treatment _____

By Whom? _____

Similar or different condition: _____ Results: _____

List any operations, surgeries, or medical procedures:

Date: _____ Procedure: _____ Date: _____ Procedure: _____

Date: _____ Procedure: _____ Date: _____ Procedure: _____

Please list any significant family illnesses _____

Have you had any spinal X-rays or MRI's in the past 5 years? If yes, when and where _____

**I acknowledge that the above information is true and complete to the best of my knowledge*

Patient Signature

Date

Doctor Signature

Medicare Patients (check one): Would you like to be able to Bend and lift with no pain Get up from sitting with no pain Get a good night's sleep with no pain
 Read with no pain Work at a computer with no pain Do your housework with no pain
 Do your yardwork with no pain Play sporting activities with no pain

Do Not Write Below This Line

Notes

Westcott Chiropractic Center

Informed Consent For Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective. It is important that each patient understand both the objective and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is the science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 movable vertebrae in the spinal column become misaligned and/or do not move properly thus causing an alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or it may be entirely asymptomatic. Subluxations are corrected and /or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxations. Our chiropractic method of correction is by specific adjustments to the spine. In addition to adjustments, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Today we will determine if we can help you. In order to do that, we need to do the following:

- 1) Review your health history
- 2) Perform an examination
- 3) Perform an X-Ray examination
- 4) Explain how chiropractic can help you

Print Name

Signature

Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____
have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Print Name

Signature

Date

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and that the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

Signature

Date

Doctor's Signature _____ **Date** _____

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Patient Current Health History

Current Health

Name and phone number of your family doctor _____

List all CURRENT illnesses or diseases you have been diagnosed with (cancers, tumors, infections, diabetes, aneurysms, etc...) _____

If you are currently taking any prescription or nonprescription medications, please list them below with dosages:

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Medication: _____ Dose: _____ Medication: _____ Dose: _____

List any allergies _____

Indicate your height and weight _____ What is your normal B.P. _____ / _____

Occupational Activities: (Circle one that best describes your job description)

Administration	Business Owner	Clerical/Secretary	Computer User
Heavy Equipment Operator	Day Care/Child Care	Construction	Health Care
Food Service Industry	Medium Manual Labor	Manufacturing	Housekeeper
Heavy Manual Labor	Light Manual Labor	Executive Legal	Other _____

Any current loss of bowel or bladder control: Yes No Any current seizures, paralysis, speech, vision problems: Yes No

What are your overall expectations from your treatment with the doctor today: _____

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Financial Policy

We strive to provide you with excellent and affordable Chiropractic care. Please read and sign in the space below.

By signing below, you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone number changes
- Your account is kept current. All self pay or insurance copayments and deductibles will be collected at the time of service payable by cash, check, Visa, Mastercard, or Discover.
- If you are unable to keep your appointment please notify us 24 hours in advance to avoid a **\$30.00 missed appointment fee**. We understand there are exceptions in certain circumstances. Speak with the receptionist if you have a concern.
- You will only be sent a statement if your balance exceeds \$5.00.
- If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance.

IF YOU HAVE HEALTH INSURANCE COVERAGE: As a courtesy to you, our office will bill your insurance company to try to collect fees payable by that particular insurance company. There is no guarantee of payment. **We are not in network with all insurance companies and there is no guarantee that you have chiropractic coverage. As medical providers, our relationship is with you, not your insurance company.**

By signing below you confirm you understand that:

- It is your responsibility to inform us of any changes to your insurance policy so that we can file a claim in a timely manner. If we do not receive your most current insurance information, this may result in you being responsible for those claims as insurance companies have a filing time limit.
- Not all services are a covered benefit with all insurance plans.
- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance plan.
- You are responsible for any non-covered charges not payable by your insurance policy.
- We will send all claim forms and documentation to ensure your claims are processed in a timely manner.
- Final determination of benefits available is determined when the claim is sent to your insurance company and we receive an explanation of benefits from them.
- After all co-pays, contracted plan reductions, and insurance payment credits are applied to your account, any remaining portion will be your responsibility.
- If you are a **MEDICARE PATIENT**, please be advised that Medicare **only covers** Spinal Adjustments in a Chiropractor's office. All other services outside of the adjustment in our office will be your financial responsibility.

We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we urge you to contact us promptly for assistance in managing your account. **WE ARE HERE TO HELP YOU.**

By signing below, you have read and understood the above Financial Policy and agree to meet all financial obligations.

Printed Name

Signature of Patient/Legal Guardian

Date

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The Westcott Chiropractic Center Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

In addition to the copy we provide you, additional detailed copies may be obtained if requested at the front desk, or copies are available to read in our lobby.

I acknowledge that I have received the Notice of Privacy Practices.

Signature of Patient or Patient's Representative

Date

Print Name

Relationship to Patient

Notice of Privacy Practices Given-patient Declined to Sign

Signature of Westcott Chiropractic Representative

Date

A. Notifier:

B. Patient Name:

C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D. _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
72050 CERVICAL X-RAYS		\$75 -
72100 LUMBAR X-RAYS		\$75 -
99203 CONSULTATION EXAM		\$120. -

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

- OPTION 1.** I want the D. _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- OPTION 2.** I want the D. _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
- OPTION 3.** I don't want the D. _____ listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:

J. Date:

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