BATES
CHIROPRACTIC & SPORTS THERAPY

# NEW PATIENT QUESTIONNAIRE

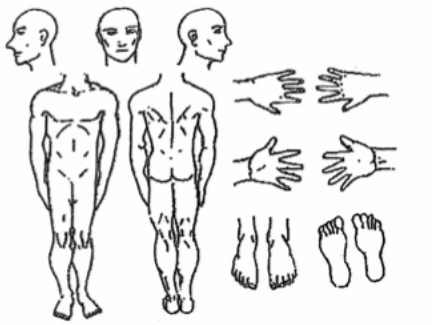
Name:_____
Primary Phone:_____Secondary Phone:_____
Address:_____
City:_____State:_____Zip:_____
SSN:_____ DOB:_____ Height:_____Weight:_____
Primary Physician:_____
Referral Source:_____
Email Address:_____

## HISTORY

Chief Complaint:_____
Where is your pain located: _____
Describe your pain:_____

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| ☐ | Sharp | ☐ | Burning | ☐ | Achy | ☐ | Twisting | ☐ | Pressure |
| ☐ | Deep | ☐ | Dull | ☐ | Heavy | ☐ | Gnawing | ☐ | Shooting |
| ☐ | Electric | ☐ | Knife Like | | | | | | |

**Please Mark the figure with the location of your symptoms:**
**Pain = X  Numbness/Tingling = O**



**How severe is your pain?**

☐ 0 Absent (No pain)
☐ 1-2 Tolerable (Tolerable without medication)
☐ 3-4 Bearable (Some activities)
☐ 5-6 Nearly intolerable (Sedentary: watch TV, reading, sitting)
☐ 7-8 Intolerable (Can not read, watch TV, need to visit ER)
☐ 9-10 Devastating (Need hospitalization for pain control)

**How long have you had your pain:** _____
**When do you have your pain:** _____
**What makes your pain worse:** _____
**Are you having difficulty with sleeping because of your pain** **Y** ◯ **N** ◯
**How long can you:** Sit _____ Stand _____ Walk _____
**Have you lost any control over bowel or bladder functions** **Y** ◯ **N** ◯
**Is your pain related to a specific injury** **Y** ◯ **N** ◯
*- If yes, please explain:*_____

**Is the injury/pain motor vehicle related** **Y** ◯ **N** ◯
*- If yes, date injury:* _____

**Is injury/pain work related** **Y** ◯ **N** ◯
**Is there a lawsuit (pending or considered)** **Y** ◯ **N** ◯
**Have you had any physical therapy (PT)** **Y** ◯ **N** ◯
*- How many sessions:* _____
*- Has PT helped:* **Y** ◯ **N** ◯

**Have you been treated by other clinicians for this problem:** **Y** ◯ **N** ◯
*- If yes, please list name, date seen, and treatment given:*_____
_____

**Have you had an epidural or facet injections** **Y** ◯ **N** ◯
*- How many:* _____ *Did they help:* _____

**Have you had a previous back or neck injury** **Y** ◯ **N** ◯
**Have you had diagnostic test performed** **Y** ◯ **N** ◯
☐ CT ☐ EMG ☐ XRAY ☐ Other:

*- If other, please list:*_____

**What do you hope/wish we can accomplish today:** _____
_____

## WORK HISTORY

**Are you working:** **Y** ◯ **N** ◯

☐ Full Time ☐ Part Time ☐ Restricted Duty: _____
☐ Unemployed / Date last worked: _____
**Occupation:**_____
**Employer:** _____
*- How long:* _____

## MEDICATIONS

**List all medications that you *currently* take:**_____
**List any medications that you have *previously* taken and if they did or did not help**

**Medicine Allergies**: Y ◯ N ◯
*- if yes, please list:* _____

## PAST MEDICAL HISTORY

Please check the boxes that apply

- ☐ Psychiatric Problems
- ☐ High Blood Pressure
- ☐ Liver Disease/ Hepatitis
- ☐ Seizure Disorder
- ☐ Asthma
- ☐ Anemia
- ☐ Alcoholism
- ☐ Gout
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Arthritis
- ☐ Cancer
- ☐ Psoriasis
- ☐ Lung Disease
- ☐ Bleeding Disorder
- ☐ Muscle Disease
- ☐ Ulcers
- ☐ Pulmonary Embolism
- ☐ Deep Vain Thrombosis
- ☐ Thyroid Disorder
- ☐ Kidney Disease
- ☐ Heart Disease
- ☐ GERD
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Anxiety
- ☐ Heart Murmur
- ☐ Diabetes
- ☐ Rheumatoid Arthritis
- ☐ Depression
- ☐ Heart Attack
- ☐ Rheumatic Fever
- ☐ Migraines
- ☐ Other _____

## PAST SURGICAL HISTORY

**List any previous surgeries:** _____

## FAMILY HISTORY

Please list any medical illness that the following blood relatives have history of

**Grandparents**:_____
☐ Living ☐ Deceased
**Father:**_____
☐ Living ☐ Deceased
**Mother**:_____
☐ Living ☐ Deceased
**Brother/Sister:**_____
☐ Living ☐ Deceased

## SOCIAL HISTORY

**Marital Status:**
☐ Single ☐ Married ☐ Divorce ☐ Separated ☐ Widow

**Number of Children:**_____
*- Ages:* _____
**Do you smoke:** Y ◯ N ◯
*- How Much:*_____ *How Long:* _____

**Previous Smoker:** Y◯ N◯
*- When did you quit:* _____
**Do you drink:** Y◯ N◯
*- How many drinks per week:* _____
**Do you use recreational drugs** Y◯ N◯
*- If yes, what type:*_____

## REVIEW OF SYSTEMS

Please check all that apply

**Constitutional**

☐ Fever ☐ Chills ☐ Fatigue ☐ Night Sweats ☐ Unexplained weight Loss/gain

☐ None

**Skin**

☐ Rashes ☐ Nails Changes ☐ Easy Bruising ☐ Color Changes
☐ Unexplained weight loss ☐ None

**Eyes/Ears/Nose/Throat**

☐ Vision Changes ☐ Hearing Loss ☐ Dizziness/Vertigo
☐ Discharge/Drainage ☐ Ringing in the Ear ☐ Hoarseness
☐ Difficulty Swallowing ☐ None

**Cardiovascular**

☐ Chest Pain ☐ Palpitations ☐ Leg Swelling ☐ None

**Respiratory**

☐ Coughing up Blood ☐ Wheezing ☐ Shortness of Breath ☐ Cough
☐ Sputum ☐ Production ☐ Recent Infection ☐ None

**Gastrointestinal**

☐ Abdominal Pain ☐ Vomiting with Blood ☐ Nausea
☐ Blood in Stool ☐ Constipation ☐ Diarrhea
☐ None

**Genitourinary**

☐ Painful Urination ☐ Blood in urine ☐ Venereal Disease
☐ Difficulty urinating ☐ Sexual problems ☐ Menstrual Problems
☐ Pregnant ☐ Menopausal ☐ None

**Musculoskeletal**

☐ Joint Swelling ☐ Stiffness ☐ Cramping
☐ Infection ☐ None

**Endocrine**

- ☐ Changes in urination
- ☐ Changes in appetite/thirst/ sweating
- ☐ Changes in heat or cold tolerance
- ☐ None

**Psychiatric**

- ☐ Depression
- ☐ Mood Changes
- ☐ Anxiety
- ☐ None
- ☐ Suicidal Thought

_____ _____

Patient Signature Physician Signature

_____ _____

Date Date

# Consent to Use and Disclosure of Protected Health Information

## Use and Disclosure of your Protected Health Information

Your protected Health Information will be used by Bates Chiropractic or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day – to – day health care operations of this office.

## Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

## Requesting a Restriction on the Use or Disclosure of Your Information

Your may request a restriction on the use or disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

## Reservation of Right to Change Privacy Practice

This office reserves the right to modify the privacy practices outlined in the Notice.

## Signature

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

_____

Name of Patient (Print)

_____

Signature of Patient Date

_____

Signature of Patient Representative

_____

Relationship of Patient Representative to Patient

_____

Office Representative Date

# Office Policy on Fees and Insurance Claims

If, by mutual agreement, we are filing your insurance, we need to inform you that you are entering a relationship with the doctor in which the doctor agrees to treat the patient and the patient agrees to pay the doctors fee for that treatment. The insurance company has no relationship with the doctor. If we contact your insurance company and you are informed that insurance benefits are available for the treatment recommended, we will file your claim for you. We are responsible only to file your claim and answer any medical questions they may have.

**Insurance companies give estimates and benefits over the telephone, but these are inly estimates and are not always accurate nor a guarantee of payment, You will be responsible for your yearly deductible, co – payment and/or coinsurance and the portion of the charges your insurance carrier does not cover or lists as a "non covered" expense. If your insurance company does not pay within sixty (60) days, your bill is due and payable immediately.**

_____ _____

Name (please print) Date

_____

Signature of Responsible Party

## ASSIGNMENT AND RESPONSIBILITY

I hereby assign to Dr. bates all of my rights, title and interest to my medical reimbursement benefits under my insurance company. I further permit a copy of this authorization to be used in place of the original. **I understand that I am financially responsible for all charges whether or not paid by my insurance carrier.** If the insurance company does not pay within sixty (60) days, I understand the balance is due immediately and agree to pay in full.

_____ _____

Signature of Responsible Party Date

## OUT OF NETWORK

I understand if Dr. Bates is not a preferred provider for my insurance company and that out of network benefits will apply. This may include, but not limited to, such things as a deductible, higher deductible and/or higher co – pay, reduced benefits.

_____ _____

Signature of Responsible Party Date

## NON-INSURANCE PATIENTS

I understand that I will be responsible for all services rendered and will pay at the time of service in full

_____ _____

Name (please print) Date

# ACKNOWLEDGEMENT FORM

I acknowledge that Bates Chiropractic and Sports Therapy “Notice of Privacy Practices” has been provided to me.

I understand I have a right to review Bates Chiropractic Notice of Privacy Practices prior to signing this document. Bates Chiropractic Notice of Privacy has been provided to me, The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or in the performance of health care operations of Bates Chiropractic, The Notice of Privacy Practices also describes my rights and Bates Chiropractic duties with respect to my protected health information.

Bates Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy of practices by accessing Bates Chiropractic website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative (please print)

_____

Description of Personal Representative (Print)

_____

Name of Privacy Officer

# CONSENT FOR TREATMENT

Health care provider are required to advise patients of the nature of the treatment to be provided, the risks, and the benefits of the treatment, and any alternative to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

a. While rare, some patients have experienced rib fractures or muscle and ligament sprain/strains following treatment.

b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.

c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, an may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote.

Osseous and soft tissue manipulation have been the subject of government reports and multidisciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches, and other related symptoms. Musculoskeletal care contributes to your overall well being. ***The risk of injuries or complications from treatment is substantially lower than that associate with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my healthcare provider:

a. The condition that the treatment is to address

b. The nature of the treatment

c. The risk and benefits of that treatment; and

d. Any alternatives to that treatment

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatment offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all present and future care with **Bates Chiropractic and Sports Therapy.**

Dated this _____ Day of _____ 20_____.

_____ _____

Signature Patient Name (Legal Guardian) Signature of Witness

_____ _____

Print Name Print Name

BATES
CHIROPRACTIC & SPORTS THERAPY

7592 Fern Ave. Suite 1502
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**Changes in Medical Insurance Carriers**
**Beginning May 1, 2016**

Dear Patients,

I am so sorry to have to inform you that after the first of the year in Jan, 2014 I started to only accept a few insurance carriers. This has come about due to the fact that insurance companies keep decreasing the amount they are reimbursing providers and the cost of running a medical office keeps rising. Not to mention the fact that we have to fight to get paid from the insurance companies.

You are able to come see us even if we do not accept your insurance. The main difference is you have to pay up front for your office visit, We will provide you a statement you can turn into your insurance company and have them reimburse you for the office visit.

Times are tough all around, that I know, but with the changes in the medical industry, more and more medical providers will no longer be accepting insurances because they can no longer run their business based on the amount insurance companies are paying for services rendered.

Listed below are the only insurance I will be accepting. If your insurance company is listed below, payment procedure will remain the same. IF you have any other medical insurance, listed below are the prices for services.
**BLUE CROSS BLUE SHEILD**: payment procedure will remain the same based on your policy
**UNITED HEALTH CARE:** Only Covers the new patient exam and an adjustment. If any muscle work/therapy aka Active release technique (ART) is performed that day you will be responsible for; which is an additional $30.00
**NON-INSURANCE PATIENTS:** we will give you a 15% discount at the time of service.
New Patient Visit $100 -$153
Follow Up Visit $50 - $85

Again, I am so sorry to have to make these changes but if I continue to accept all insurance carriers there is a chance I will have to close my practice. I worked too hard to get where I am and I do not want to stop caring for you. It would be sad if I had to close my business because of the decreasing amount insurance companies pay for medical services.

Thank you for your time and understanding

Dr. Ryan L. Bates, D.C.


7592 Fern Ave. Suite 1502
Shreveport, LA 71105
www.bateschirosport.com

**Changes in Medical Insurance Carriers**
**Beginning January 1, 2014**

Listed below are the insurances I will be accepting after the first of the year. If your insurance company is listed below the payment procedure will remain the same. If you have any other medical insurance, listed below are the prices for the services.

**INSURANCES ACCEPTED:**
**Blue Cross Blue Shield**
**United Health Care**: will pay an additional $30.00 for the muscle work/therapy aka A.R.T

**OTHER INSURANCE:** (15% discount included)
New Patient: $100 - $153
Follow Up Visit: $50 - $85

Please sign and date this form stating you are aware and understand the changes that are being made regarding medical insurance carriers and payment amounts.

_____
Date

_____ _____
Print Name Witness Name

_____ _____
Signature Witness Signature

Submit