FOCUSED HEALTH
Chiropractic

Office Policies

I agree to take full financial responsibility for my chiropractic care in the event that the assumed coverage (Excellus, MVP, Workers' Compensation, No Fault Insurance, etc.) is denied.

I understand that office charges a $30 fee for returned checks and for appointment cancellations with less than 24 hour notice or for not attending a scheduled appointment.

I also understand that payments/co-payments are expected at the time of service or the office reserves the right to charge a $5 service fee.

Informed Consent

Chiropractic care, like all forms of care, has potential inherent risks associated with its application. Your chiropractic physician will do everything in his/her power to minimize the possibility of these occurrences as our patients' health and well-being is our primary concern. Some of the risks which we wish to make patients aware of are post-treatment soreness, physical therapy burns, fractures, sprains/strains and strokes. If you have any questions or concerns regarding any of the above potential risks, please do not hesitate to address them with your doctor.

Health Insurance Portability and Accountability Act of 1996 (HIPAA), Privacy Practices

The above act ensures a patient's right to privacy regarding Personal Health Information and it is our office policy to maintain confidentiality to the highest degree with all patient information. A complete copy of the HIPAA is available from the reception desk upon your request. Please feel free to ask your doctor or office personnel regarding any questions or concerns.

For Focused Health Chiropractic to disclose private health information about you to parties not covered in our Notice of Privacy Practices, you will need to complete this section.

_____ Yes, you may provide information to the parties listed below:

____

____

____

_____ No, I do not wish Focused Health Chiropractic to discuss my information with any party other than myself.

By signing below, I acknowledge that I have read and understand the above policies.

Patient **OR** Legal Guardian signature:_____________________________ Date:_________

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Date:					
Last Name:		First Name:		MI:	Suf:
Address:					
City:		State:	Zip:		

Phone (H):		Phone (C):	
Date of Birth:			
Email:			
Who may we thank for the referral?			
Marital Status:		Spouse/Partner:	

Employer:		Occupation:	
Address:			
City:		State:	Zip:
Phone (W):			

Insurance:		Active Date:	
Subscriber:		Patient relation to subscriber:	
Emergency Contact Name/Phone:			
Primary Care Physician:			
Phone:			

Chief Complaint:

FOCUSED HEALTH
Chiropractic

OFFICE FINANCIAL POLICY

Please read and check the paragraph indicative of your current insurance policy. Please sign and date below.

_____**Excellus:** Chiropractic is covered by most Excellus plans. Patient is responsible for payment on day of service, this includes copayments and deductibles. When insurance has been exhausted, you will be charged directly.

_____ **MVP or Cigna:** Patient is responsible for payment on day of service, this includes copayments and deductibles. MVP/Cigna may limit your chiropractic care based upon medical necessity. When insurance has been exhausted for any reason, you will be charged directly. ***Dr. Sirianni is not a participating provider with MVP/Cigna.***

_____**Aetna/United Health Care**: Some plans will require prior authorization for chiropractic care and may limit treatments based upon medical necessity. Patient is responsible for payment on day of service, this includes copayments and deductibles. When insurance is exhausted for any reason, you will be charged directly. ***Dr. Burton is not a participating provider in United Health Care***.

Senior Care:

_____**Excellus Blue Choice Medicare**: Primary care physician referral is required . Your doctor will determine the number of allowed chiropractic treatments for each referral. The patient is responsible for updating referrals when necessary. There may be an additional fee ($20) for extraspinal (knee, ankle, wrist, etc) treatments that are not covered by this plan.

_____**Medicare**: Medicare covers spinal manipulation only. Physical therapy modalities such as electric/muscle stimulation ($6), ultrasound ($6) and heat/ice ($4) will be additional charges. Patient is responsible for payment on day of service.

Payments are due at time of service. Insurance coverage on individual plans may vary. Check with your individual insurance company to confirm chiropractic coverage.

Signature____ Date_______________

FOCUSED HEALTH
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OFFICE FINANCIAL POLICY

Please read and check the paragraph indicative of your current insurance policy. Please sign and date below.

_____**Workers' Compensation**: If you require treatment for an injury that occurred while performing your normal employment, you may be eligible for 100% coverage by your employer's workers' compensation insurance. In such cases, to ensure your coverage, it is *your responsibility* to report your injury to your employer in writing and fill out all appropriate reports. Failure to do so will jeopardize your coverage. Should your case be denied, you would become liable for the services rendered and you will be charged our standard fees. *All missed appointments /cancellations without 24hr notice are subject to cancellation fees.*

_____**Auto Accidents/No Fault Insurance**: If you are seeking treatment as a result of an auto accident you may be eligible for 100% coverage by your No Fault Insurance. Some companies have a deductible that must be met first. It is *your responsibility* to contact your insurance company and fill out the appropriate reports. Should your insurance decline to pay for your case, you would become liable for all services rendered and you will be charged our standard fees. *All missed appointments /cancellations without 24hr notice are subject to cancellation fees.*

Fee for service is required at time of service by cash or check only. Insurance coverage on individual plans may vary.

Patient **OR** Legal Guardian Signature____Date_____________

FOCUSED HEALTH
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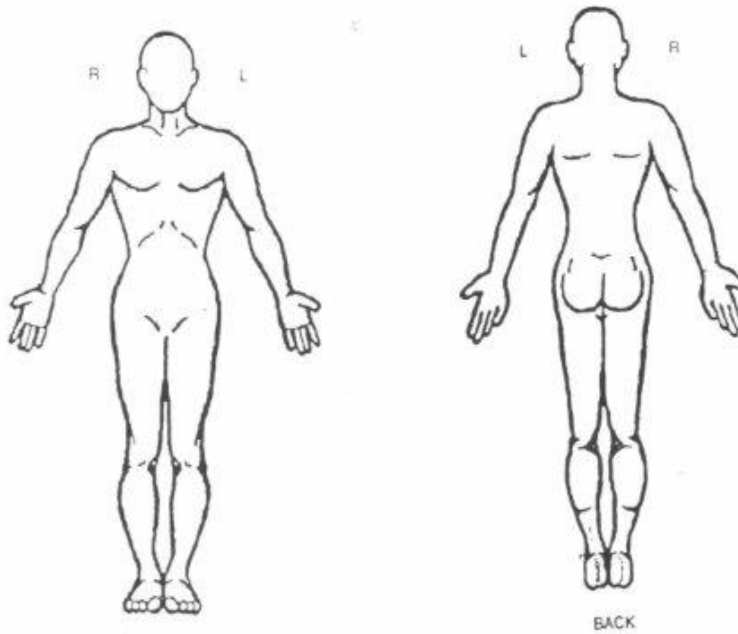
PAIN DIAGRAM

NAME____ DATE______________

INSTRUCTIONS: Please use the following symbols on the body outlines below to describe your pain and/or discomfort.

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
^^^^^^	======	OOOO	....	/////	XXX
^^^^^^^^	=========	OOOOOO	....	////////	XXXX
^^^^^^	======	OOOO	....	/////	XXX



FRONT

What is your pain RIGHT NOW?

No pain ______________________________ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

FOCUSED HEALTH
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Review of Systems

Name_________________________________Height___________Weight_________Date______________

Please circle any conditions or symptoms which are currently or have previously caused any problems.

General Symptoms
Headache
Recent fever
Dizziness
Loss of sleep
Nervousness/Anxiety
Loss of weight
Rashes/itching
Bruise easily
Asthma
Bowel/Urinary problems
Prostate
Chest pain
Diabetes
Autoimmune disease

Muscles & Joints
Neck pain
Back pain
Shoulder pain
Elbow pain
Wrist pain
Hand pain
Hip pain
Knee pain
Foot pain
Arthritis
Numbness/tingling
Swollen joints

Cardio Vascular
High blood pressure
Stroke
Poor circulation/Raynaud's
High cholesterol

Gastrointestinal
Indigestion/reflux
Nausea
Constipation
Diarrhea
Gall bladder trouble

Gynecological
Painful menstruation
Menopausal symptoms

Are you currently taking birth control? Yes/No
Births_______________
C-Sections__________

EENT
Blurred vision
Frequent colds
Sinus infection
Difficulty swallowing

Have you ever had any fractures? Yes/No

Have you ever been in a car accident? Yes/No

Have you ever been hospitalized? Yes/No

Have you ever smoked in the past? Yes/No
Currently? Yes/No

Have you ever been diagnosed with cancer? Yes/No

Have you tested positive for the HIV virus? Yes/No

Do you have any known allergies including medications?
If so, to what?
____
____
____

List any current medications:

Condition	Medication

Place a check for family history

	Grand parents	Parents	Siblings
Cardiovascular			
Cancer			
Autoimmune disease			
Diabetes			

Past surgeries:____
____