Neuropathy Consult ROF

blueprint to Neuropathy

Please fill out the application entirely and legibly. We need all information for insurance purposes.

Name _____ **Nickname** _____

Address _____

City _____ **State** _____ **Zip** _____

Phone _____ **Email** _____

We will need to contact you both by phone & email. Please be sure to give us the best phone number to reach you

Date of Birth _____ **Social Security** _____

If you have Medicare, we need you to list your SSN above or provide us with the Medicare card

Spouse's Name _____ **Phone Number** _____

Your Occupation _____ **Retired?** Yes ☐ No ☐

REVIEW OF SYMPTOMS

Please check all that apply

☐ Foot Pain	☐ Diabetes	☐ Spinal Stenosis	☐ Cancer	☐ Pinched Nerve
☐ Hand Pain	☐ High Cholesterol	☐ Degenerative Disc	☐ Chemotherapy	☐ Poor Circulation
☐ Low Back Pain	☐ High Blood Pressure	☐ Vascular Problems	☐ Arthritis in Hands	☐ Joint Replacement
☐ Neck Pain	☐ Pacemaker/ Defibrillator	☐ Leg Pain	☐ Arthritis in Feet	☐ Foot Surgery
☐ Foot Numbness	☐ Herniated Disc	☐ Plantar Fasciitis	☐ Implanted Cord/ Bladder Stimulator	☐ Poor wound healing
☐ Hand Numbness	☐ Bulging Disc	☐ Morton's Neuroma	☐ Sciatica	☐ Excessive thirst or urination

PRESENT HEALTH CONDITION

In order of importance, list the health problems you are most interested in getting corrected:

1. _____
2. _____
3. _____
4. _____

List approximately how long you have noticed these problems:

1. _____
2. _____
3. _____
4. _____

Is there a certain time of day any of these problems are better or worse?

_____
_____
_____
_____

List the things you have used for these problems:

Gabapentin Neurontin Lyrica Cymbalta Physical Therapy Pain Medications Aleve Tylenol Ibuprofen Motrin Chiropractic Massage Therapy Injections Creams

Is your balance/walking ability affected?
If yes, please describe:

_____
_____
_____
_____

What do you think is causing your problem?

_____
_____
_____
_____

Name of all doctors you have seen for these problems and treatment you received:

_____

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Have your symptoms: ☐ Improved ☐ Worsened ☐ Stayed the same

List anything that makes your condition worse _____

_____

List anything that makes your condition better _____

_____

How would you describe the symptoms? Please check ALL that apply

☐ Aching Pain	☐ Numbness	☐ Hot Sensation	☐ Cramping
☐ Stabbing Pain	☐ Tingling	☐ Throbbing Pain	☐ Swelling
☐ Sharp Pain	☐ Pins & Needles Pain	☐ Dead Feeling	☐ Burning
☐ Tiredness	☐ Heavy Feeling	☐ Cold Hands/Feet	☐ Electric Shocks

Is this condition interfering with any of the following?

☐ Sleep	☐ Work	☐ Daily Activities
☐ Recreational Activities	☐ Walking	☐ Standing

SOCIAL HISTORY

Do you smoke? Yes ☐ No ☐ If yes, how many cigarettes daily? _____

Do you drink? Yes ☐ No ☐ If yes, how many drinks per week? _____

Do you exercise regularly? Yes ☐ No ☐ If yes, please describe type & how often: _____

_____

CURRENT PAIN LEVELS

How would you rate your pain in the last week?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN POSSIBLE

If you had to accept some level of pain after completion of treatment, what would be an acceptable level?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN POSSIBLE

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PRACTICE INFORMATION HERE

Patient Quality Of Life Survey

Name: _____ ***Date:*** _____

Please take several minutes to answer these questions so we can help you get better.
(Please circle as many that apply)

1. How have you taken care of your health in the past?
   - a. Medications
   - b. Emergency Room
   - c. Routine Medical
   - d. Exercise
   - e. Nutrition/Diet
   - f. Holistic Care
   - g. Vitamins
   - h. Chiropractic
   - i. Other (please specify): _____

2. How did the previous method(s) work out for you?
   - a. Bad results
   - b. Some results
   - c. Great results
   - d. Nothing changed
   - e. Did not get worse
   - f. Did not work very long
   - g. Still trying
   - h. Confused

3. How have others been affected by your health condition?
   - a. No one is affected
   - b. Haven't noticed any problem
   - c. They tell me to do something
   - d. People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?
   - a. Job
   - b. Kids
   - c. Future ability
   - d. Marriage
   - e. Self-esteem
   - f. Sleep
   - g. Time
   - h. Finances
   - i. Freedom

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PREVIOUS HEALTH HISTORYHEALTH

This is a confidential record of your medical history and pertinent personal information. The doctor reserves the right to discuss this information with medical and allied health professionals per the informed consent. Copies of this record can only be released by your written authorization, unless you sign here indicating that we can release copies by your verbal request.

Name _____ ***Signature*** _____

Please give name, address, and office phone number of your primary care physician.

Name _____ ***Phone*** _____ ***Address*** _____

When were you last seen there?

_____

May we send them updates on your treatment/condition? Yes ☐ No ☐

List ALL allergies/sensitivities to medication, food, and other items here:

Item you react to:	*Reaction:*

List the prescription drugs you are currently taking (or you may attach a list):

Name	*Dose (mg or IU)*	*Times Daily*

List all nutritional supplements (vitamins, herbs, homeopathics, etc.) as above:

5 Are there health conditions you are afraid this might turn into?

a. Family health problems
b. Heart disease
c. Cancer
d. Diabetes
e. Arthritis
f. Fibromyalgia
g. Depression
h. Chronic Fatigue
i. Need surgery

How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:

What are you most concerned with regarding your problem?

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific

What would be different/better without this problem? Please be specific

What do you desire most to get from working with us?

What would that mean to you?

Balanced Living Chiropractic Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/ year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Assumption of Risk, Waiver & Release of Liability Agreement: Microcurrent Therapy

The assumption of Risk and Waiver and Release of Liability Agreement ("Agreement") is entered into between Balanced Living Chiropractic of Rochester PLC (the "Company") and _____ ("You/Client") this date _____. In consideration of the opportunity to receive microcurrent therapy offered by the Company and the use of the Company's facilities, I hereby agree as follows:

1. Products and Services. Microcurrent devices are state-of-the-art micro-based e-stim devices that come pre-programmed for typical home and sports-related issues and injuries. Microcurrent technology increases cell energy (ATP), improves cellular oxygenation, encourages cell repair and boosts protein synthesis.
2. Risks. I understand and accept the risks associated with the products and services offered and the use of the Company's facilities. I acknowledge that the use of such products, services and/or the Company's facilities may subject me to the possibility of physical and/or emotional injury (which could be minimal, serious, and/or result in death.)
3. Assumption of Risk, Waiver and Release. I acknowledge and voluntarily assume the risk of any and all injury, accident or death which may result from the use of such products, services or the Company's facilities, to the fullest extent allowed by the law. I hereby release and hold harmless the Company, its officers, directors, employees, agents, volunteers and contractors (collectively, "Releasees") from any claim, demand, loss, liability, expense, damages, and/or attorney fees and costs whatsoever, known or unknown, arising from, related to, or resulting from these risks, including those caused by the negligent acts or omissions of any or all of the Releasees and/or anyone using the products, services and/or the Company's facilities, to the fullest extent of the law.

Balanced Living Chiropractic Privacy Policy

The Health Insurance Portability and Accountability Act of 1996 was designed to protect your rights to privacy of your protected health information. This act was passed with the intent to provide security of the electronic transmission of your individual health information.

At Balanced Living Chiropractic your personal health information (i.e. x-rays, initial medical history, progress record, etc.) and your public or nonpublic personal information (i.e. your SS#, your name, address, and phone number, date of birth, marital status, etc.) are never shared with any outside sources unless you personally request and authorize us to do so. We are not contracted with any insurance company except for Medicare and AETNA.

Release of Information

I authorize Balanced Living Chiropractic to release photocopies of any and all information contained in my medical file or office records including but not limited to opinions, reports, notes, orders, x-rays, photographs, lab or test results or other documentation regarding my medical history, physical condition or medical condition resulting from any injury, accident, disease, disorder or dysfunction of whatsoever kind or nature necessary to process insurance claims to my insurance company for reimbursement for my expenses for services performed at this office or for payment of any unpaid balance to Balanced Living Chiropractic PLLC.

Patient Name: _____ Signature: _____ Date:
Parent or Guardian: _____ Signature: _____ Date:

Credit Card on File

Dear Patient:

We have implemented a policy requiring a credit card to be held on a secure file for each patient. As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is stored and later used to pay your bill. **Physicians extend more credit than any business except banks**, who charge interest and fees to do so. As you may also be aware, the current healthcare market has resulted in much higher deductibles, coinsurances and copays not known at the time of service.Our new policy will require that your credit card be held on secure file. Balances of $5 or less will be charged immediately, otherwise you will receive a statement from us with your remaining balance. If the balance is not pain within 30 days of notification, we will charge your balance to your credit card on file.

This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment. You are also encouraged to call your insurance company to confirm your benefits before your visit.

Thank you in advance for your cooperation.

I, the undersigned, Authorize Balanced Living Chiropractic of Rochester PLC, to charge the portion of my bill that my financial responsibility to the following credit card. Balances of $5 or less will be charged immediately, otherwise I will receive a statement from Balanced Living Chiropractic of Rochester PLC for the balance that I owe. I understand that my credit card will be charged 30 days after statement date if other arrangements have not been made. I will receive a receipt via email only. I agree to notify and update my credit card as necessary. A $35 fee will be added to my account if my credit card declines.

_____AMEX _____VISA _____MasterCard _____Discover

Credit card number:_____ Expiration Date:_____

Patient Name:_____

Cardholder Name: _____

Cardholder Signature: _____

Credit Card billing address: _____

Cardholder e-mail address: _____

Missed Appointments Policy

I acknowledge that if I do no show up, or call the office 24 hours prior to my appointment that I am directly responsible for a $25 cancellation/missed appointment fee.I acknowledge I have read all sections and have accepted the terms and statements made above:

Patient Name: _____ Signature: _____ Date: Parent or Guardian: _____ Signature:_____ Date:

About Medicare Coverage

FOR MEDICARE PATIENTS ONLY

Medicare only pays Doctor of Chiropractic for limited services. Under Section 1862(a)(i) of the Medicare Act, Medicare will only pay for services that it determines to be "reasonable and necessary".

Medicare only pays for chiropractic adjustments defined as:

Acute (such as a strain and/or sprain)-defined as a new injury, identified by x-rays or physical exam. The results of chiropractic adjustments is expected to be an improvement in, or arrest of progression of the patient's condition.

According to Medicare law, most of the available services in our office are NON-COVERED including:

- Office visits- where no adjustments made, to evaluate and manage, re-evaluate advice or counsel.
- Adjustments to an area other than the spine (i.e. shoulder, knee, arm, leg, etc.)
- Nutritional Supplements, Neuropathy home protocols
- Maintenance Care- you are stable and not making any more improvements.
- Wellness Care- to promote better health.

Our office is a participating provider with Medicare and does accept assignment. By Medicare laws, we must bill Medicare for all chiropractic adjustments received in our office, even if they are non-covered by Medicare standards. You may choose for Medicare to be billed for all NON-covered services. After denial by Medicare, those services can be then followed to your other insurance company(s). Your other insurance company(s) will pay according to the terms of your contract.

Statement of Understanding and Authorization:

I have agreed to receive these services and understand that I am responsible for all charges incurred regardless of my insurance coverage. I have read and understand the limitations of my Medicare coverage and effects it may have on any supplemental or secondary policies. I understand that I am responsible for deductible amounts, non-covered charges and any denied services that exceed Medicare guidelines. I request any reimbursement by my insurance company to be made to Balanced Living Chiropractic. I authorize the release of any information needed to process my claims.

Patient Name: _____ Signature: _____ Date: Parent or Guardian: _____ Signature:_____ Date:

A. Notifier: Balanced Living Chiropractic of Rochester PLLC

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (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
Manual Manipulation or Chiropractic Adjustment X-rays (72040,72070,72100) Examinations (99202,99203,99212,99213) Maintenance adjustments (98940)	-Medicare pays for active care only not maintenance care of the spine. Medicare does not pay for extremity adjustments. -These are NON-COVERED items and services under Medicare when ordered and/or delivered by a Chiropractor	98940-$30-45 98941-$30-45 98942-$30-45 $50-200 $50-250 $40

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:

blueprint nutrition

Trust Your Gut Wellness Evaluation

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to LGS go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please take the quiz to help our doctors evaluate how we can help your condition and any underlying triggering limiting your health in process

Let's get started.

Please circle any that apply to you prior to taking the quiz below:

Sub-Clinical symptoms including:
Headaches and migraines

Hormone imbalance including:
PMS
Emotional imbalance

Gastrointestinal issues including:
Abdominal bloating and cramps or painful gas
Irritable Bowel Syndrome
Ulcerative Colitis
Crohn's Disease and other intestinal disorders

Respiratory Conditions including:
Chronic sinusitis
Asthma
Allergies

Autoimmune Conditions including:
Diabetes Mellitus
Lupus
Rheumatoid Arthritis
Fibromyalgia
Chronic Fatigue

Developmental and social concerns including:
Austism
ADD/ADHD

Skin Conditions: (urticaria)
Eczema
Skin rashes
Hives

Please complete our TYG wellness quiz. While there's more to it than a single quiz, the answers below can give you a good idea of how happy your gut really is. Circle the number that most closely fits, then add up your results.

TYG Wellness Questionnaire	None	Mild	Moderate	Severe
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3

	None	Mild	Moderate	Severe
Asthma, hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Ulcerative colitis or celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight Trouble	0	1	2	3

YOUR TOTAL: _____