NEW HAMPSHIRE
SPINE + SPORT

Personal Information

Last Name:_____ First Name_____ MI_____

Address_____ City_____ State_____ Zip_____

Phone-home (____)_____ cell (____)_____ work (____)_____ Age_____

Date of Birth_____/_____/_____ Sex M F Height: _____ Weight: _____

Emergency Contact _____ Phone_____ Relationship _____

Primary Care Physician:_____

Address_____Phone (_____)_____

How did you hear about us? _____

Payment Information

I will not be using insurance and will be a self-paying patient_____

signature

If using insurance please fill out below

Insured's Name _____

Patient's relationship to Insured- ____self ____spouse ____ child ____other

Name of Insurance Co_____

Insurance Address _____

Insurance Phone (_____)_____ Policy #_____

If visit is related to workers compensation:

Claim # _____*WC Insurance Company:* _____

*Contact information*_____

If visit is related to an auto accident: *State where the accident occurred* _____

Claim number: _____ *Insurance company:* _____

Symptom questionnaire

Describe the problem (s): _____

_____

When and how did this begin?_____

What makes this problem worse?_____

What makes this problem better?_____

What does the pain feel like? Dull Sharp Achy Stabbing Electric Tight Stiff Restricted

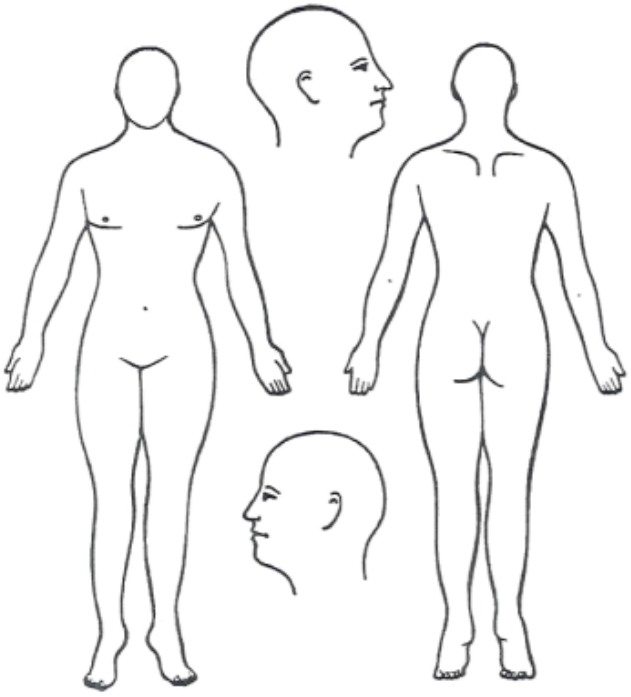
Do the symptom (s) travel to a different part of your body?_____

Circle the number which describes how intense the pain is, with 10 being most intense:

0 1 2 3 4 5 6 7 8 9 10

Does the problem change by time of day? _____

Please mark or circle on the diagram symptom (s) occur:



Please list any: circle *none* if none

Injuries: *None*

_____

Illnesses: *None*

_____

Surgeries: *None*

_____

Allergies: *None*

_____

Medications:: *None*

_____

Do you smoke? No Yes: pack(s)/day _____

Do you have a family history of any of the following?

	Circle		Describe all YES responses
Cancer	No	Yes	
Diabetes	No	Yes	
Heart Disease	No	Yes	
Stroke	No	Yes	
High blood pressure	No	Yes	
Rheumatoid Arthritis	No	Yes	
Connective Tissue disorders	No	Yes	

Review of Systems: Are you currently having or have you had problems with your:

	Circle		Describe all YES responses
Recent fevers or infections	No	Yes	
Recent unexplained weight loss	No	Yes	
Unexplained fatigue	No	Yes	
Unexplained pain at night	No	Yes	
Blurred or double vision	No	Yes	
Difficulty speaking or swallowing	No	Yes	
Loss of consciousness	No	Yes	
Unexplained loss of balance	No	Yes	
Frequent headaches	No	Yes	
Facial numbness	No	Yes	
Dizziness	No	Yes	
Nausea	No	Yes	
Changes in bowel or bladder function	No	Yes	
Cough	No	Yes	
Shortness of breath	No	Yes	
Pelvic floor numbness	No	Yes	
Changes in your skin	No	Yes	
Arm or leg swelling	No	Yes	

Dr. Steven Baroody, D.C.
NH SPINE AND SPORT • 1650 ELM STREET • SUITE 301 • MANCHESTER, NH 03101 • 603-203-3185

DIRECT ASSIGNMENT OF BENEFITS & RIGHTS

Provider: Steven B. Baroody, DC Patient: _____ Date: _____

In consideration of your undertaking to render care, I agree to the following:

1. RELEASE OF INFORMATION: You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me at your treatment facility.

2. RIGHT TO RECEIVE INFORMATION: I authorize my chiropractic provider the authority to affix my signature as noted below to obtain medical information from any hospital, medical provider, etc. as necessary as it relates to the care being provided by my chiropractic doctor.

3. RIGHT TO RECEIVE PAYMENT: I irrevocably authorize and assign to you, the chiropractic provider, the right to receive direct payment from my attorney or any insurance company which may become obligated to pay me at sums. I further authorize the endorsement of my name to any draft containing my name to which you are legally entitled.

4. ASSIGNMENT OF RIGHT TO SUE: In the event any insurance company or attorney obligated by contractual agreement to make payment to me for your service charges refuses to make such payment upon demand by you, I irrevocably hereby assign and transfer to you the cause of action that exists in my favor against any such company or attorney and authorize you to prosecute said action either in my name or your name as you otherwise resolve said claim as you see fit. I understand that whatever amount you do not collect from said insurance proceeds (whether it be all or part of what is due) shall be paid by me.

5. I also irrevocably assign to you, the chiropractic provider, and grant the right of lien against any and all claims against any third party whose negligence may have caused my injury, including their insurance, up to the amount of the bill for treatment, as it relates to my healthcare as provided by you.

6. I waive the Statute of Limitations regarding my doctor's right to recover from me directly.

7. I hereby acknowledge that I am receiving (or about to receive) health care services from New Hampshire Spine and Sport and am advised that they are willing to wait for payment for these services, provided there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim. I understand that if it is determined either (a) there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the Doctor(s) or make other provisions for the protection of the interest of the Doctor(s); or (b) if a liability claim exists and my attorney refuses to agree to protect the interest of the Doctor(s) or if I have not engaged the services of an attorney, payment for services rendered by the above-named Doctor(s) will be made on a current basis and my account paid in full immediately. In any event, I hereby promise to pay my bill in full within 10 days from the date my liability claim is settled or after the passage of three (3) months from the date of my last treatment, whichever comes first.

8. If any payment for any services rendered under this agreement becomes delinquent, the patient or patient's guardian shall be responsible for payment of any and all Court costs, attorney's fees, service of process fees and any additional reasonable costs incurred in order to collect or that are associated with collecting monies due on the patient's account.

Dated this _____ day of _____, 20_____

_____
Patient's Signature

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INFORMED CONSENT TO CARE

Provider: Steven B. Baroody, DC Patient: _____ Date: _____

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 “arterial dissection” that typically is 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, 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 a 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 are as is deemed appropriate for my circumstances. 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.

Patient Name:_____

Signature:_____Date:_____

Parent or Guardian:_____

Signature:_____Date:_____

Dr signature verifying discussion: _____