BASIS MEDICAL

APPLICATION FOR CARE

IS THIS AN EMERGENCY CONDITION? ☐ YES ☐ NO

TODAY'S DATE: _____ HRN: _____

PATIENT DEMOGRAPHICS

NAME: _____ BIRTH DATE: _____ AGE: _____ ☐ MALE ☐ FEMALE

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ EMAIL: _____

HOME PHONE: _____ MOBILE PHONE: _____ WORK PHONE: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED DO YOU HAVE INSURANCE? ☐ YES ☐ NO

SOCIAL SECURITY NUMBER: _____ DRIVER LICENSE NUMBER: _____

EMPLOYER: _____ OCCUPATION: _____

SPOUSE'S NAME: _____ SPOUSE'S EMPLOYER: _____

NUMBER OF CHILDREN AND AGES: _____

EMERGENCY CONTACT: _____

CONTACT NUMBER: _____ RELATIONSHIP: _____

HISTORY OF COMPLAINT

PLEASE IDENTIFY THE CONDITION(S) THAT BROUGHT YOU TO THIS OFFICE: Primarily: _____

Second: _____ Third: _____ Fourth: _____

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints by checking the number:

Primarily: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Second: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Third: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Fourth: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ Mid-day ☐ Late PM

HOW LONG DOES IT LAST? ☐ IT IS CONSTANT ☐ I EXPERIENCE IT ON AND OFF DURING THE DAY

☐ IT COMES AND GOES THROUGHOUT THE WEEK

HOW DID THE INJURY HAPPEN? _____

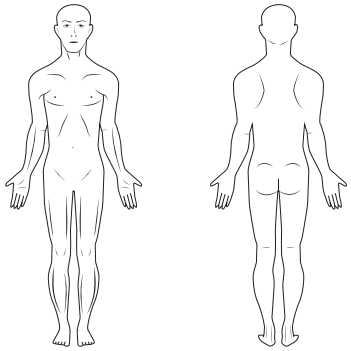
CONDITION(S) EVER BEEN TREATED BY ANYONE IN THE PAST? ☐ NO ☐ YES IF YES, WHEN: _____

BY WHOM? _____ HOW LONG WERE YOU UNDER CARE: _____

WHAT WERE THE RESULTS? _____

NAME OF PREVIOUS CHIROPRACTOR: _____ ☐ N/A

*__Please Mark__ the areas on the diagram with the following __letters__ to describe your symptoms:
__R = R__adiating __B = B__urning __D = D__ull __A= A__ching __N = N__umbness __S =S__harp/Stabbing __T= T__ingling



What relieves your symptoms? _____

What makes them feel worse? _____

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL :	USUAL ACTIVITY LEVEL:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IS YOUR PROBLEM THE RESULT OF ANY TYPE OF ACCIDENT? ☐ YES ☐ NO

IDENTIFY ANY OTHER INJURY(S) TO YOUR SPINE, MINOR OR MAJOR, THAT THE DOCTOR SHOULD KNOW ABOUT:

_____

_____

PAST HISTORY

HAVE YOU SUFFERED WITH ANY OF THIS OR A SIMILAR PROBLEM IN THE PAST? ☐ YES ☐ NO

IF YES, HOW MANY TIMES? _____ WHEN WAS THE LAST EPISODE? _____

HOW DID THE INJURY HAPPEN? _____

OTHER FORMS OF TREATMENT TRIED: ☐ NO ☐ YES - IF YES, PLEASE STATE WHAT TYPE OF TREATMENT: _____

_____ WHO PROVIDED IT: _____

HOW LONG AGO? _____ WERE THE RESULTS ☐ FAVORABLE ☐ UNFAVORABLE

PLEASE EXPLAIN: _____

PLEASE IDENTIFY ANY AND ALL TYPES OF JOBS YOU HAVE HAD IN THE PAST THAT HAVE IMPOSED ANY PHYSICAL STRESS ON YOU OR YOUR BODY: _____

IF YOU HAVE EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS, PLEASE INDICATE WITH A **P** FOR IN THE **PAST**, **C** FOR **CURRENTLY** HAVE AND **N** FOR **NEVER** HAVE HAD:

Broken Bone		Fracture		Osteo Arthritis	
Dislocations		Disability		Diabetes	
Tumors		Cancer		Cerebral Vascular	
Rheumatoid Arthritis		Heart Attack			

Other serious conditions: _____

PLEASE IDENTIFY ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem.

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
Injuries			
Surgeries			
Childhood Diseases			
Adult Diseases			

SOCIAL HISTORY

Smoking:		Cigars		Pipe		Cigarettes - Consumption:		Daily		Weekends		Occasionally		Never
Alcoholic Beverage						Consumption:		Daily		Weekends		Occasionally		Never
Recreational Drug Use						Consumption:		Daily		Weekends		Occasionally		Never

Hobbies -Recreational Activities-Exercise Regime: How does your present problem affect the following: _____

_____

FAMILY HISTORY

DOES ANYONE IN YOUR FAMILY SUFFER WITH THE SAME CONDITION(S)? ☐ YES ☐ NO

IF YES, WHOM? ☐ Grandmother ☐ Grandfather ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Son(s) ☐ Daughter(s)

HAVE THEY EVER BEEN TREATED FOR THEIR CONDITION? ☐ YES ☐ NO ☐ I DON'T KNOW

ANY OTHER HEREDITARY CONDITIONS THE DOCTOR SHOULD BE AWARE OF: ☐ NO ☐ YES _____

I hereby authorize payment to be made directly to Basis Medical for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Basis Medical for any and all services I receive at this office.

PATIENT OR AUTHORIZED PERSON'S SIGNATURE: _____ DATE COMPLETED: _____

DOCTOR'S SIGNATURE: _____ DATE FORM REVIEWED: _____

PATIENT'S NAME: _____ HR#: _____

BASIS MEDICAL

PAYMENT INFORMATION AND AGREEMENT

Welcome to Basis Medical. Please read the following billing and payment policies carefully.
If you have questions about your financial obligations, please let us know immediately.

Third Party Payer-Auto/Liens and Legal cases *Initial _____

1. I am ultimately responsible for all charges. I understand that **whether I have an attorney or not**, I must sign a lien to cover all outstanding charges not covered by the policy medical payments.
2. I understand that in the event that Medical Payment coverage is exhausted, I will be responsible for all outstanding charges due thereafter. **I am responsible for monitoring this status**. If you do not understand how to do this, please ask and we will go over this with you.

Private Insurance and Medicare *Initial _____

1. I am ultimately responsible for all of the charges regardless of whether I have insurance or not and I authorize Basis Medical to bill my insurance on my behalf and agree to assign any insurance benefits otherwise payable to me to go Basis Medical for services rendered.
2. I understand that Basis Medical will not accept responsibility for collecting my insurance claim or for negotiating a settlement for me if a dispute arises between my insurance company and me. If such a dispute should arise, I agree to pay the outstanding balance and then pursue reimbursement from my insurance company thereafter.
3. I agree to pay any portion of the bill not covered by my insurance each month, unless contracted rates apply and the charges are disallowed.

ALL Patients Listed Above *Initial _____

1. Basis Medical will only wait up to 90 days after the date of service for any insurance covered payments that may be due. If the insured has not paid after 90 days, I agree to make arrangements to pay the balance due to Basis Medical and pursue reimbursement from the covering insurance company thereafter or I **may** be allowed to assign the balance to an attorney lien.
2. If charges remain unpaid after 90 days and I haven't made satisfactory arrangements with the billing office, I agree to pay an administrative service charge of 1 1/2% per month (APR 18%) on unpaid balances after 90 days.
3. If any legal action or collections activity is taken by Basis Medical to collect the balance due on my account, I agree to pay reasonable attorney's fees and costs and/or collection fees.

Worker's Compensation *Initial _____

We must receive authorization to treat you within one week from your insurance carrier before we can continue treatment. Reports of your progress and attendance will be submitted to your physician and the carrier/employer and we may need to discuss your case with your carrier/employer or physician.

All Patients *Initial _____

1. When canceling an appointment, I agree to provide notice at least before 8:00 am of the same business day. Failure to do so will incur a **$25.00 fee**. **Insurance companies and worker's comp do not pay for canceled/no show appointments; I understand that these charges are solely my responsibility.**
2. We do not require a physician referral in order to provide your rehab. However, many insurance companies will not pay for services without a physician referral. We will be happy to recommend a physician to all patients who do not have one.

I understand and agree to the above payment contract. A copy is as valid as the original.

PATIENT'S NAME: _____ SIGNATURE :_____ DATE: _____

BASIS MEDICAL

ASSIGNMENT OF BENEFITS *Initial _____

I, _____ Hereby authorize _____
(Name of Insured) (Name of Insurance Carrier)

Payable and mailed directly to:

Basis Medical
4383 Northlake Blvd., Suite 309, Palm Beach Gardens, FL 33410

The medical benefits otherwise payable to me for their services, but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to Basis Medical any benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statues for any service and/or changes provided by Basis Medical.

MEDICAL INFORMATION RELEASE FORM (HIPAA RELEASE FORM) *Initial _____

Release of Information:

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.

This information may be released to:

☐ Spouse _____ ☐ Child(ren) _____ ☐ Other _____

☐ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages:

Please call ☐ My home _____ ☐ My work _____ ☐ My cell _____

If unable to reach me:

☐ You may leave a detailed message ☐ Please leave a message asking me to return your call

RELEASE OF RECORDS *Initial _____

I authorize Basis Medical to:
1. Release any and all medical records, reports, history, diagnosis, treatment, MRI reports, and all other records of any kind or nature, for services rendered in connection with my care and treatment.
2. If it is necessary to obtain documents from my Basis Medical file, I consent to the acceptance of a photocopy; hereof in lieu of the original documents.
3. Obtain copies of my medical records in connection with care at their facility.

I have carefully read the above 3 sections and agree to all terms:

PATIENT'S NAME: _____ SIGNATURE :_____ DATE: _____

BASIS MEDICAL

PATIENT'S NAME: _____ DATE: _____

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

Analysis | Examination | Treatment
As a part of the analysis, examination, and treatment, you are consenting to the possible following procedures:

- Spinal manipulative therapy
- Range of motion testing
- Muscle strength testing
- Radiographic studies
- Ultrasound
- Other_____
- Palpation
- Orthopedic testing
- Postural analysis
- Hot/cold therapy
- Physical therapy exercises
- Spinal decompression
- Medical consultation
- NCV/EMG testing
- Basic neurological testing
- Vital signs
- Electrical stimulation/EMS
- Massage therapy

The outlined procedures, including chiropractic adjustments, will only be performed by the request of the patient and recommendation by the physician. In no circumstance will services be performed without the understanding and authorization from the patient. A treatment plan will be established following an evaluation, at which time the possible listed services will be discussed between physician and patient before they are performed.

The nature of a chiropractic adjustment.
The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

The material risks inherent in chiropractic adjustment.
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients feel stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.
Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during the examination. Stroke has been the subject of tremendous agreement. The incidences of stroke are estimated to occur between one in a million and one in five million cervical adjustments. The other complications are also generally described as rare.

DO NOT SIGN UNTIL YOU HAVE READ/UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read ☐ or have had read to me ☐ the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Scuderi and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

PATIENT'S NAME: _____ SIGNATURE :_____ DATE: _____

BASIS MEDICAL

PATIENT'S NAME: _____ DATE: _____

Reason for Today's Visit: _____

_____

_____

CHECK ALL SYMPTOMS YOU ARE CURRENTLY EXPERIENCING:

Headache		Swollen/Painful Joints		Menopausal Problems	
Neck Pain		Skin Problems		Menstrual Problem	
Jaw Pain, TMJ		Dizziness		PMS	
Shoulder Pain		Loss of Balance		Bed Wetting	
Upper Back Pain		Fainting		Learning Disability	
Mid Back Pain		Double Vision		Eating Disorder	
Low Back Pain		Blurred Vision		Trouble Sleeping	
Hip Pain		Ringing in Ears		Ulcers	
Back Curvature		Hearing Loss		Heartburn	
Scoliosis		Depression		Heart Problem	
Numb/Tingling arms, hands, fingers		Irritable		High Blood Pressure	
Numb/Tingling legs, feet, toes		Mood Changes		Low Blood Pressure	
Pregnant (Now)		ADD/ADHD		Asthma	
Frequent Colds/Flu		Allergies		Difficulty Breathing	
Convulsions/Epilepsy		Prostate Problems		Lung Problems	
Tremors		Impotence/Sexual Dysfunction		Kidney Trouble	
Chest Pain		Digestive Problems		Gall Bladder Trouble	
Pain w/Cough/Sneeze		Colon Trouble		Liver Trouble	
Foot or Knee Problems		Diarrhea/Constipation		Hepatitis (A,B,C)	
Sinus/Drainage Problem					

Please list any medication allergies that you have: _____

_____

_____

Please list any medications you are currently taking (and dosage if known): _____

_____

_____

PATIENT'S NAME: _____ SIGNATURE :_____ DATE: _____
(print)

BASIS MEDICAL

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Function	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Bathing				
Dressing				
Grooming				
Oral Care				
Sleep				
Toileting				
Sit To Stand				
Walking				
Climbing Stairs				
Lifting Children				
Eating				
Shopping				
Cooking				
Driving				
Reading				
Using The Phone				
Housework				
Managing Medication				
Managing Finances				
Carrying Groceries				
Doing Laundry				
Computer Use				
Static Sitting				
Static Standing				
Yard work				
Sexual Activities				
Other:				

PATIENT'S NAME: _____ SIGNATURE :_____ DATE: _____
(print)

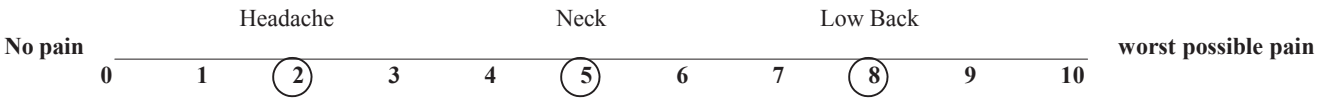
QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name: _____ Date: _____

Instructions: Please circle the number that best describes the question being asked.

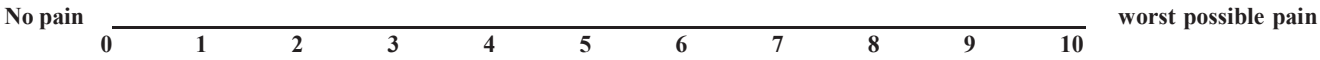
Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

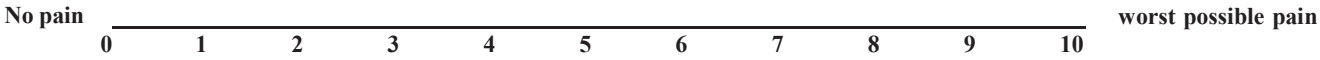


---

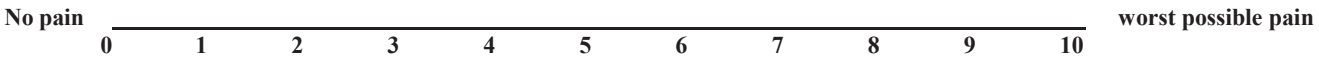
1 – What is your pain RIGHT NOW?



2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

OTHER COMMENTS:

_____

_____

_____

_____ _____

Patient's Signature Examiner's Signature