Rolnick
Chiropractic Wellness Centre

Hi!

We are so glad that you have chosen our office to help you in your journey towards health and wellness in your life.

There are a few forms to complete prior to your arrival at the office. Please allow yourself 20-30 minutes to fill them out in their entirety.

The Health Profile form gives us information about your current health concerns as well as your health history. Please be as thorough as possible. The more information given to the doctors, the better equipped they are to understand the condition of your body, how it got to this point and how best to care for you.

You will find additional forms which require your review and signature as well. Please bring all the completed forms to the office at your visit.

If for any reason you are unable to keep this appointment, please call our office as soon as possible.

We're looking forward to meeting you.

Sincerely,

Dr. Ellie Rolnick

Shano Connors
New Patient Coordinator

Rolnick Chiropractic Wellness Centre

Tel: (207) 283-1168
Fax: (207) 282-5248
Dr Eleanor Rolnick
413 Alfred St
Biddeford, Me 04005

CASE HISTORY HEALTH PROFILE

Personal Information

Personal Information

Full name:	**Date:**
Address: Street City State Zip	
Home phone:	**Work phone:**
Cell phone:	**Email address:**
Best number to contact you:	
Date of birth:	**Age:**
No. of children:	**Pregnant? Yes ☐ No ☐**
Marital status: M S W D	
Occupation:	
Employer's name & address:	
Spouse/guardian name:	
Spouse's Occupation/Employer:	

Finances

We will do out best to explain our fees to you in advance of your acceptance of care. We provide a higher level of care than what many insurance companies cover. Most insurance will cover part of your care but will not cover all of it. You are responsible for any portion that is not covered by your insurance plan.

Name of person responsible for account: _____

Do you have health insurance ? Yes ____ No ____

Do you have Medicare coverage? Yes ____ No ____

Name of Insurance Company: _____

Insurance Policy Number: _____

Insurance Co. phone number: _____

Insurance Company address:

_____

Addressing What Brought You Into This Office:

What brings you here ??

What illness or condition brought you to our office?

1. ______________________________ Begin date: ______________

2. ______________________________ Begin date: ______________

What have you done for this condition or illness? Was it of benefit? ______________________________

____

What aggravates your condition or illness? ______________________________

How long ago did you first feel something similar to this? ______________________________

- -

Why do you think your body failed to heal itself this time? ______________________________

What do you think might lie at the root of your illness? ______________________________

What do you feel your body needs to heal? ______________________________

Are there ways you may have sabotaged your own health? ______________________________

Physical – Mental – Chemical

Traumas create negative brain patterns. Please list below significant traumas/events in your life:

Physical traumas (slips, falls, surgeries, car accidents, etc.) : ______________________________

____

Mental/Emotional traumas (work, relationships, abuse, finances, self-esteem: ______________________________

____

Chemical traumas (drugs, alcohol, medicines, diet, toxins): ______________________________

____

History of Disease

History of Disease Please mark the following conditions: **P**= Had in the past **C**= Currently have

___Alcoholism	___Cold Sores	___Epilepsy	___Irregular Periods	___Mumps	___Ringing in the Ears
___Allergies	___Constipation	___Gall Bladder Issues	___Low Blood Sugar	___Neck Pain	___Sinus Issues
___Anemia	___Convulsions	___Gout	___Malaria	___Nervousness	___Stroke
___Arterio-sclerosis	___Depression	___Headaches	___Measles	___Neuritis	___Thyroid Issues
___Arthritis	___Diabetes	___Heart Attack	___Menstrual Cramps	___Pleurisy	___Tuberculosis
___Asthma	___Diarrhea	___Heart Disease	___Migraines	___Pneumonia	___Vaccine Injury
___Back Pain	___Eczema	___HIV (AIDS)	___Miscarriage	___Polio	___Venereal Disease
___Cancer	___Emphysema	___High Blood Pressure	___Multiple Sclerosis	___Rheumatic Fever	___Whooping Cough

Other (please explain) ______________________________

Rate Yourself

Key factors… rate yourself and then see if you can improve them over the next few weeks…

On a scale of 1-10, how healthy do you consider yourself?	1	2	3	4	5	6	7	8	9	10
On a scale of 1-10, how much energy do you have on an average day?	1	2	3	4	5	6	7	8	9	10
On a scale of 1-10, how much stress are you under on an average day?	1	2	3	4	5	6	7	8	9	10
On a scale of 1–10, how would you rate your level of happiness ?	1	2	3	4	5	6	7	8	9	10

Handling Stress

Let's face it, we all have stress… the important thing is to recognize our triggers and to have tools to manage it...

Where in your body do you hold or carry your stress? _____

What tools/treatments have you used to try to reduce your stress? _____

How much younger would you feel if your stress was significantly reduced? _____

Is money a stress in your life? _____

How's your sleep?

Adequate sleep is crucial for our bodies to run at their very best. Share your sleep habits with us…

How many hours do you sleep each night ? _____

Do you have difficulty falling asleep or staying asleep? _____

When was the last time you bounced out of bed in the morning? _____

Let's go a little deeper…

Just a few more questions to help us better understand several aspects of the person that is 'you' ...

Do you feel like you are in touch with your life purpose? _____

What things do you do to support your own health ? _____

How many times per week do you meditate or sit quietly reflecting on life? _____

What bad habits do you need to release? _____

Do you believe your thoughts influence your healing response? _____

Are you worthy of optimal and vibrant health? _____

Are you ready to invest the time, money, and energy necessary to improve your health? _____

_____

I consent to a professional and complete chiropractic examination. I understand that any fee for services rendered is due at the time of service.

Print Patient Name: _____ **Date:** _____

Patient Signature: _____

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EXPLANATION OF MEDICARE BENEFITS TO THE PATIENT

Medicare will cover CHIROPRACTIC ADJUSTMENTS ONLY. Allowed services will go towards your $147.00 deductible if it has not already been met. Services will be allowed dependent on medical necessity. Medicare will not pay for maintenance or wellness care. You will be informed when and if your visits will no longer be covered and/or if your care is maintenance or wellness care.

Medicare will pay 80% of the allowable – recognized charges. They do not pay for exams, vitamins or other supplies, which might be used in a Chiropractic office. Examples of non-covered charges include exams, nutritional supplements, orthopedic supports, orthotics, as well as other supplies not listed here.

The Standard Fee in this office is $40.00 to $50.00 per visit. We do accept assignment. This means that once your deductible has been met, we will wait for payment from Medicare. However, should the claim not be paid by your insurance, you would then be responsible for the visit. Your responsibility will be between $5.00 and $10.00 per visit unless other arrangements have been made for assignment of a companion plan health insurance.

Again, as a service to our patients we will fill out and send in all necessary Medicare insurance forms. We will also submit and accept assignment to any companion plans other than Medicaid, as we do not participate with this particular insurance company. If a deductible needs to be met with your companion plan, it will be your responsibility to make this payment when we receive notification that it has not been met.

Upon my signature of the Explanation of Medicare Benefits to the Patient, I attest that things were explained to me to my understanding; I, being the patient. I also agree to and understand the conditions and services for which I am responsible for payment.

Patient's
Signature:_____Date:_____

Witness
Signature:_____Date:_____

MEDICARE SECONDARY PAYOR QUESTIONNAIRE

Patient Name: _____ Medicare # : _____ Date: _____

Medicare law requires that we determine if your medical services might be covered by another insurer. In order to assist us, please answer the following questions:

1.Is your injury/illness due to:

A- A work related accident/condition? _____ No _____ Yes

Name of Workers Compensation Plan: _____

Policy or ID #: _____ Accident Date: _____

B- A condition covered under the Federal Black Lung program? ___ No ___ Yes

C- An automobile accident? _____ No _____ Yes

Name of auto insurance _____

Policy or ID #: _____ Accident Date: _____

Accident Location: _____

D- The fault of another party? _____No _____Yes

Name/address of liability insurer _____

_____

Name of insured: _____

Policy or ID #: _____

Accident Date: _____

Accident Location: _____

2. Are you eligible for coverage under the Veterans' Administration? _____No ____Yes

3. Are you employed ? ___ No, date of retirement: _____

___ Yes, employer name and address: _____

Do you have Employer Group Health Plan Coverage? _____No _____Yes

Insurance Company: _____ Policy #: _____

4. Is your spouse employed? ____ No ____ Yes, spouse's name: _____

Employer name and address: _____

Are you covered under your spouse's Employer Group Health Plan? ____ No ____ Yes

If yes, insurer name and address: _____

_____

Policy# _____ Group #_____

5. Are you a dependent covered under a parent's/guardian's Employer Group Health Plan?

_____ No _____ Yes, employer name and address: _____

Insurer's name and address: _____

Name of insured: _____ Policy # _____

6. Are you on Medicare because of a disability or ESRD? _____

Thank you for your cooperation in ensuring that your medical services will be billed to the proper insurer(s).

_____ _____

Date Signature of policy holder

MEDICARE ASSIGNMENT FORM

THIS ASSIGNMENT FORM IS TO BE USED BY BOTH MASSACHUSETTS AND MAINE PROVIDERS AS VERIFICATION BY BENEFICIARIES THAT PAYMENTS CAN BE MADE DIRECTLY TO THE PROVIDER. THIS FORM REPLACES THE ASSIGNMENT CARDS USED IN THE PAST.

Medicare # :_____ Last Name: _____ First Initial: _____

Provider No. # 148897
Provider Name/Address : Rolnick Chiropractic 413 Alfred St Biddeford, ME 04005

I request that payment by the medical insurance program be made directly to this physician on any unpaid bills for services furnished to me by that physician.

I authorize release to SSA's carriers any information needed to process this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original.

Address: _____

Signature: _____ Date: _____

MEDICARE B - Privacy Act Authorization Form

Rolnick Chiropractic has requested access to certain information contained in your Medicare B files. In accordance with the Privacy Act of 1974, we cannot grant request without your written authorization.

If you wish the information disclosed to the above party, please sign the following authorization form and return it with the request.

Please be specific as to dates and description of services contained in the information you wish released.

We recommend that you make this authorization valid for a period of at least two months. Blanket authorization will not be acceptable.

I authorize **Rolnick Chiropractic** to inquire about and to be given the following information from my Medicare records.

Date of Service or other information	Control Number from Explanation of Benefits
_____	_____
_____	_____

This authorization is valid from the date of _____ to _____ .

_____	_____	_____
Date	Signature of Policy Holder	Medicare Number:

Rolnick Chiropractic Wellness Centre

Shared Decision Making and 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 begin with a health history, followed by the examination procedures indicated. The information we gain along with our clinical experience helps us develop recommendations for any further evaluation, referral and/or care. During the exams, several tests may be preformed, which may include, among others, range of motion, muscle strength, orthopedic, basic neurological testing, and radiographic studies. These tests will be performed to maximize your comfort; however some of these tests may be uncomfortable. There is minimal risk associated with performing these diagnostic procedures. Following your history, examinations, and possible imaging studies, an indicated "next step" recommendation will be made. We may recommend proceeding with chiropractic care, additional studies, or referral to a different provider. For most patients, we are able to proceed with chiropractic care.

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. An adjustment serves to improve neurological function as well as restore normal joint motion, reduce swelling and inflammation in a joint, reduce pain in the joint, and improve 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 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 home administered hot or cold therapies, fractures, disc injuries, strokes, dislocations and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs 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. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

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 option and to secure other options 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.

Patient Name: _____ Signature: _____Date:_____

Parent/Guardian Name: _____Signature:_____Date:_____

Witness Name:_____Signature:_____Date:_____ _

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information ("PHI") to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your PHI, and of other important matters about your PHI. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your PHI that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting Pam Gaudette, C.C.C.A..

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.