McCANN CHIROPRACTIC CENTER

Daniel J. McCann, D.C.

Practice Limited to the Treatment of Neuro-musculo-skeletal Conditions

Spinal manipulation therapy

Adjunctive procedures

Spinal rehabilitation

5 Brookwood Avenue
Carlisle, PA 17013

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Integrating chiropractic and exercise rehabilitation for the treatment of neck and back pain.

Welcome

The doctor and staff of the McCann Chiropractic Center welcomes you and wants to provide you with the best care possible. We will conduct a thorough history and physical examination to decide if we can assist you. If your condition is one that will not respond to chiropractic care, you will not be accepted as a patient and referred to another health care provider.

Patient Identification:

Name: ______________________________

Address: ______________________________

____

Telephone: Home ______________ Work: ______________

OK to call there? Yes ( ) No ( )

Social Security Number: ______________ Male ( ) Female ( )

Date of Birth: __________ Marital Status: Single ( ) Married ( )

Age: ________ Divorced ( ) Widow ( )

Height ________ Weight ________

Contact Name in Case of Emergency: (Name) ______________

Telephone # __________ Name of Parent/Guardian(if minor)__________

Is your condition due to a Work Injury or Auto Accident Yes ( ) No ( )

If yes please explain______________________________

Acceptance as Patient:

I understand and agree that McCann Chiropractic Center has the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of gathering information so that the doctor can determine whether to accept me as a patient.

Date: ______________ Signature: ______________________

Patient name:______________________

CURRENT CONDITION:

What is your chief complaint or the main reason you have presented to the office? ______________________

____

When did it begin ? ____

Have you seen any other physician for this complaint? If so, who and when______________________

____

Has the condition disabled you from work? ______________If so, give dates______________________

What have you tried to help you with the pain ?____

Has it helped ?____

On a scale of 1-10, place an X in your current pain level you are feeling right now:

NORMAL	LOW PAIN	MODERATE PAIN	INTENSE PAIN	EMERGENCY
( ) 0	( ) 1	( ) 4	( ) 7	( ) 10
	( ) 2	( ) 5	( ) 8	
	( ) 3	( ) 6	( ) 9	

On that same scale, how would your pain rate when it is at its worst (use a number) ______________

On that same scale, how would you rate your **average** pain level: (use a number) ______________

HEALTH HISTORY:

Have you experienced any of the following symptoms:

1. Unexplained weight loss ( ) Yes ( ) No ______________________________
2. Pain/difficulty or lack of control of bladder or bowel function ( ) Yes ( ) No______________
3. Diagnosed with cancer ( ) Yes ( ) No : If yes what kind______________________
4. Had a recent infection/ fever (last 3 months) ( ) Yes ( ) No ______________________
5. Have been diagnosed with lupus, rheumatoid arthritis, osteoporosis, osteoarthritis or gout ( ) Yes ( ) No ______________________________
6. Increased night pain , not relieved with rest ( ) Yes ( ) No ______________________
7. Have you been diagnosed with high blood pressure, cardiovascular disease or had a stroke? ( ) Yes ( )No ______________________________
8. Have you been diagnosed with diabetes ? ( ) Yes ( ) No______________________

Additional Comments (Do not complete: For the Doctor)______________________________

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____

____

Date: ______________________ Signature______________________

Patient Name: ____________________________

Medical Testing:

1. Have you had any diagnostic work done for this condition (MRI, CAT Scan, xray, blood work, nerve conduction, etc.) ( ) Yes ( ) No If yes, please list the procedure and dates:

____

____

2. Are you currently taking any medication, prescription or over the counter (Tylenol, Advil) vitamin supplement or herbs? ( ) Yes ( ) No If yes please list ______________

____

3. Please list any operations that you have had: ______________________

____

____

4. Is acceptable to send copies of your reports/ findings if necessary to your family physician? ( ) Yes ( ) No If yes, please list you family doctor ______________

Family History

1. Please list any significant health conditions of your immediate family (i.e. diabetes, heart attack, cancer etc.) ______________________________

____

____

General Health

1. Do you smoke or chew tobacco? ( ) Yes ( ) No If yes, how much____________
2. Do you use alcohol? ( ) Yes ( ) No If yes, how much ______________
3. Which of the following describes y our diet? ( ) good ( ) average ( ) poor ________
4. Do you have a pacemaker, transplanted organ or metal implant? ( ) Yes ( ) No______
5. For female patients, is there any chance that you may be pregnant? ( ) Yes ( ) No_____

Insurance Information:

Patient Name: ________________ Spouse Name: ____________________

Patient SS#: ________________ Spouse SS#: ____________________

Patient employer: ____________ Spouse Employer:__________________

Billing: ( ) Cash ( ) Medicare ( )Workers Compensation ( ) Auto

Insurance: ( ) Blue Cross/Blue Shield ( ) Physicians Care ( ) Penn State/Geisenger

( ) Other ________________Spouse Date of Birth - __________

How were you referred to the office:( ) Sprint Yellow Pages ( ) Friend ____________

( ) Sign/Location ( ) Medical doctor/ Health Care Professional ____________

( ) Other____________

Type of care :

Why chiropractic? People choose chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (RELIEF CARE). Others are interested in having the cause of their problems as well as the symptoms corrected and relieved (CORRECTIVE CARE). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with chiropractic care (PREVENTATIVE CARE). These are the three phases of care. The doctor will weigh your needs and desires when recommending your schedule of care. However, the prepared recommendation is an incorporation of all three phases.

Please check the type of care desired so that we may be guided by your wishes:

( ) RELIEF CARE ( ) CORRECTIVE CARE ( ) PREVENTATIVE CARE

( ) Check here if you want the doctor to select the most appropriate care for you.

____

____

The staff of the McCann Chiropractic Center will do everything it can to help with the reimbursement for the services provided including: verifying your coverage and submitting the forms for you. Please understand that no insurance attempts to cover all costs. It is your responsibility to pay any deductible or copayment not covered by your policy. I agree to authorize the release of my medical records necessary on my behalf for insurance reimbursement.

I understand that I am personally responsible to give to the doctor any payment made directly to me, for whatever reason, if payment is not made to the doctor instead. If I suspend or terminate care at this office, any outstanding charges for professional services will be immediately due and payable. In addition, I will be responsible to pay any legal fees necessary for any account balance delinquency on my behalf.

Date: ____________ Signature: __________________________

INFORMED CONSENT

After reviewing your health history, the Doctor will examine you and may require other diagnostic tests, such as X-rays, MRI or Lab tests, to make an accurate diagnosis and treatment plan. The Doctor will select a treatment plan which best suits your needs. You will be informed of all alternative treatments available to you. Occasionally the plan may have to be altered during treatment, due to unexpected changes. We encourage you to ask the Doctor any questions you may have so you fully understand your condition.

At this time, we would like to inform you of the risks that may occur from Chiropractic treatment. They are as follows: muscle soreness and irritation, headache, pain, muscle spasm and stiffness. In rare instances, dizziness and/or nausea may occur.

If there is anything you do not understand, please discuss it with the Doctor before signing the statement below.

I certify the information I provided for the health history is true and factual to the best of my knowledge. I understand the office policy and the risks of chiropractic treatment, which were supplied in the statement above. Any additional information which may occur will be supplied to you. I hereby consent to chiropractic treatment.

____________________________ ____________
(Patient's Signature) (Date)

The patient is unable to consent because ____________________________
(i.e. underage, etc.) I, therefore, consent for the patient.

____________________________ ____________
(Signature) (Date)

Relationship to patient: ____________________________

MEDICARE LIFETIME AUTHORIZATION & ASSIGNMENT

NAME OF BENEFICIARY ____________________ HEALTH INS. # ______________________

" I request that payment of authorized Medicare benefits be made either to me or on my behalf to Daniel J. McCann, D. C. or any representative of MCCANN CHIROPRACTIC CENTER for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

______________________________ ______________________________

BENEFICIARY SIGNATURE DATE

______________________________ ______________________________

NAME OF BENEFICIARY HEALTH INS. CLAIM #

____

MEDICARE POLICY #

"I request that payment of authorized Medigap benefits be made either to me or on my behalf to Daniel J. McCann, D.C. or any representative of MCCANN CHIROPRACTIC for any services furnished me by that physician/supplier. I authorize any holder of Medicare information about me to release to MCCANN CHIROPRACTIC CENTER any information needed to determine these benefits payable for related services.

______________________________ ______________________________

BENEFICIARY' SIGNATURE DATE

MEDICARE ADVANCE NOTICE

Physician Notice:

Medicare will only pay for services that it determines to be :reasonable and necessary" under section 1842(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. I believe that, in your case, Medicare is likely to deny payment for the following service, New patient Exam, Therapy, for the following reason(s):

1. Medicare may not pay for this many visits/treatments within this period of time.
2. Medicare does not pay for this service when performed by a D.C. (Doctor of Chiropractic).
3. Medicare usually does not pay for like services by more than one doctor during the same time period.
4. Medicare may not pay for this many visits/treatments.

BENEFICIARY AGREEMENT:

I have been notified by my physician (or another representative of McCann Chiropractic Center, that in my case , Medicare is likely to deny payment for the service(s) identified above , for the reason(s) stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Signed,

________________ Date

________________ Beneficiary's Signature

ACTIVATOR METHODS, INC., P.O. Box 80317, Phoenix AZ 85060-0317
(602) 224-0220 Fax: (602) 224-0230

REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

NAME (Please Print): ______________________ DATE: __________

AGE: ______ DATE OF BIRTH: __________ OCCUPATION: __________

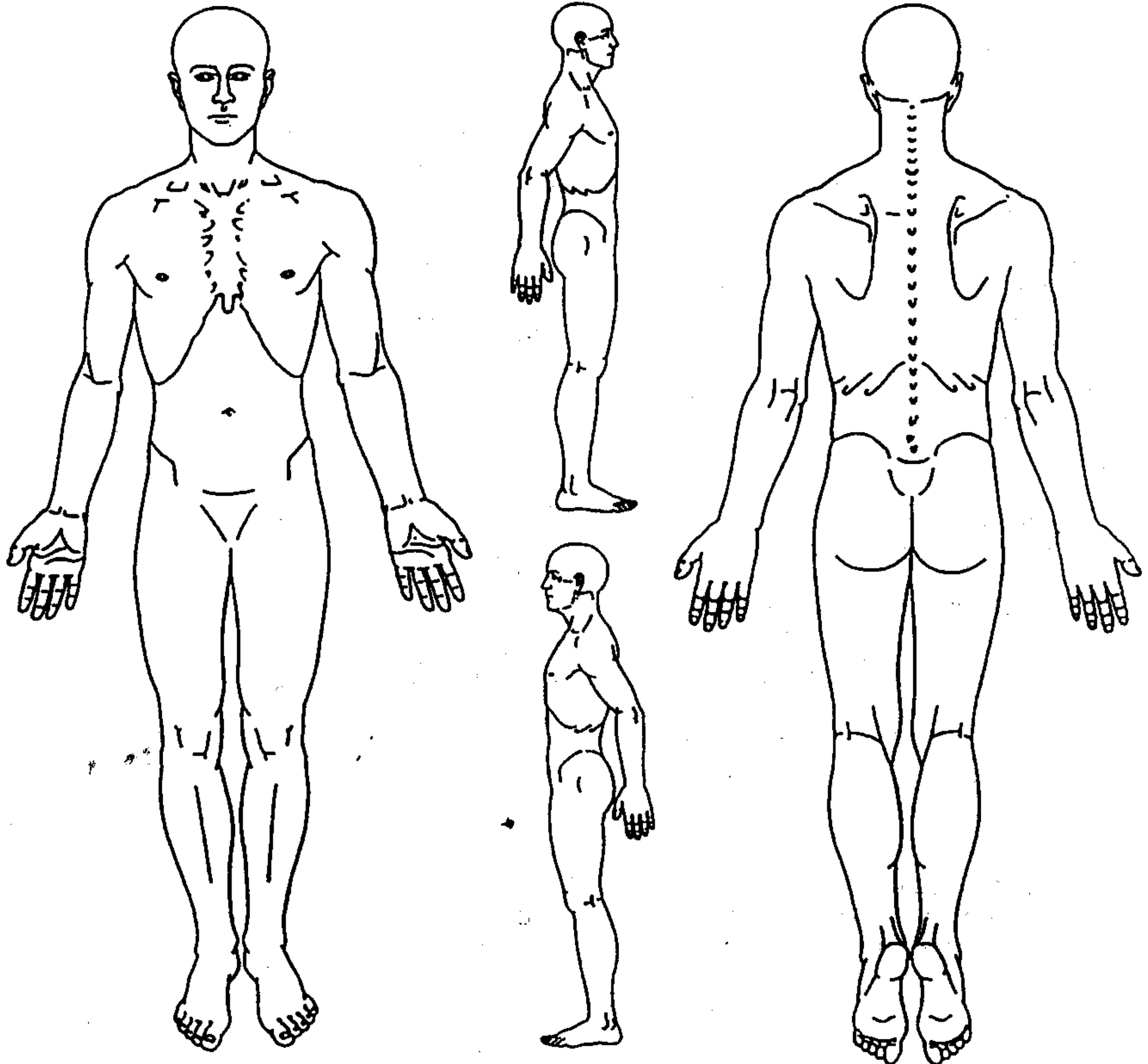
HOW LONG HAVE YOU HAD LOW BACK PAIN? ___YEARS ___MONTHS ___WEEKS

IS THIS YOUR FIRST EPISODE OF LOW BACK PAIN? ___YES ___NO

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form.)

KEY:
A=ACHE **B**=BURNING **N**=NUMBNESS
P=PINS & NEEDLES **S**=STABBING **O**=OTHER



OVER PLEASE