Office Policy

Spinal Health Orientation: To maximize your benefits from chiropractic care, a New Patient Orientation is scheduled on Monday evenings at 6:15. **We strongly recommend that someone in your support system attend so that they are informed of chiropractic and therefore can help you during Initial Intensive Care.** We also ask that you bring anyone interested in chiropractic with you so that they better understand health care and consider the benefits of chiropractic for their own health care needs.

Family Health: We believe that health should be a family goal. Chiropractic care is not limited to just spinal pain. Underlying spinal conditions can cause malfunction of other body systems and, if left uncorrected, can have devastating effects on your total health. As a courtesy to you, we provide complimentary consultations and spinal screenings for our patient's families and friends to help determine if current health problems may be helped by chiropractic care. Let us know when you would like to schedule these screenings for your family.

Keep Us Informed: Since you are under our care, we must know of any changes or problems with your health. Changes in your health, even though they may not seem important to you, may have a significant bearing upon our treatment plan for you.

Appointments: Keeping your appointment is a critical component in your care and is a major factor in determining your results. If you must cancel, please give as much notice as possible. In order for you to continue to make progress and your condition to improve, you may make up your missed appointment the same week. We recognize that your time is very important to you and our goal is to always be on schedule and not have any of our patients wait.

Cooperation: Your cooperation is of vital importance to the outcome of your care. In addition to the treatment you will receive while in our office, it is also extremely important that you follow recommendations concerning exercise, sleeping habits, lifting, housework, heat or ice applications, work limitations, and recreation. These activities may have a significant bearing upon your progress. We will be happy to answer any questions you may have.

Children: This is a family clinic and children are always welcome! A play area is located in the waiting room and has toys for a variety of ages.

My purpose in coming to Trochim Family Chiropractic is for:
☐Temporary Pain Relief
☐Long Term Pain Relief
☐Improved Health and Wellness
☐Increased Function

Are you interested in any of the following?
☐Yoga Class
☐Nutritional Counseling

_____ _____
Patient, Parent, or Legal Guardian Signature Date

This page is front and back.

TROCHIM FAMILY CHIROPRACTIC
60 Meadowview Ave, Unit 100
Rocky Mount, VA 24151
(540) 483-1811

INSURANCE ASSIGNMENT POLICY STATEMENT

Dear Patient:

You have selected "INSURANCE ASSIGNMENT" as the method of choice to take care of your financial obligation with this office.
It is important you realize that in this office we offer the option of "INSURANCE ASSIGNMENT" strictly as a courtesy to our patients, and, as such, our patients must understand and agree to the following:

1. That you are ultimately responsible for full payment for any and all services rendered.
2. That you must pay all deductibles in full. Your co-insurance balance may not exceed $150.00 and your insurance balance may not exceed $450.00.
3. That co-insurance must be paid at the same time of service, or at the beginning of each and every week.
4. Personal Injury Cases where liability has been established and verified by our Insurance Department, we may or may not carry your account until the case is resolved. The clinic manager will determine if your case is accepted.
5. That if your carrier has not paid a claim within 60 days of submission, you are responsible to take an active part in recovery of your claim and that after 90 days you will be responsible for payment in full for any outstanding balance.
6. That in the event you discontinue your program of care prior to doctor's consent, you are responsible for payment of any outstanding balance, and the courtesy of insurance assignment is immediately discontinued.
7. Trochim Family Chiropractic has affordable payment plans for those who do not have insurance, are partially insured, or choose not to use their existing insurance policy. Please ask the front desk for information regarding the Financial Hardship Policy and discount medical plans.

ALL SUPPLIES WILL BE PAID FOR IN CASH AND ARE NON-REFUNDABLE. (Braces, cervical pillows, supports, etc.)

This insurance assignment policy must be followed. We ask that you sign this form as acknowledgement that our policy was explained to you, that you understand it, and that you accept full financial responsibility.

Date: _____

Patient's Name: _____

Patient, Parent, or Legal Guardian Signature: _____

Notice of Privacy Practices Acknowledgment

Trochim Family Chiropractic

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date:_____ Attempt:_____

Staff Name:_____

Activities of Daily Living: A Functional Outcome Assessment

Name: _____ Date: _____

Please check a box in each category as it pertains to your specific condition.

Bathing: ☐ Can perform with no difficulty (0) ☐ Can perform with little difficulty (1) ☐ Can perform with moderate difficulty (2) ☐ Can perform with great difficulty or need little assistance to perform (3) ☐ Cannot perform or require assistance to perform (4) ☐ Cannot perform at all (5)	**Dressing:** ☐ Can perform with no difficulty (0) ☐ Can perform with little difficulty (1) ☐ Can perform with moderate difficulty (2) ☐ Can perform with great difficulty or need little assistance to perform (3) ☐ Cannot perform or require assistance to perform (4) ☐ Cannot perform at all (5)
Grooming: ☐ Can perform with no difficulty (0) ☐ Can perform with little difficulty (1) ☐ Can perform with moderate difficulty (2) ☐ Can perform with great difficulty or need little assistance to perform (3) ☐ Cannot perform or require assistance to perform (4) ☐ Cannot perform at all (5)	**Toileting:** ☐ Can perform with no difficulty (0) ☐ Can perform with little difficulty (1) ☐ Can perform with moderate difficulty (2) ☐ Can perform with great difficulty or need little assistance to perform (3) ☐ Cannot perform or require assistance to perform (4) ☐ Cannot perform at all (5)
Transferring: ☐ Can perform with no difficulty (0) ☐ Can perform with little difficulty (1) ☐ Can perform with moderate difficulty (2) ☐ Can perform with great difficulty or need little assistance to perform (3) ☐ Cannot perform or require assistance to perform (4) ☐ Cannot perform at all (5)	**Walking:** ☐ Can perform with no difficulty (0) ☐ Can perform with little difficulty (1) ☐ Can perform with moderate difficulty (2) ☐ Can perform with great difficulty or need little assistance to perform (3) ☐ Cannot perform or require assistance to perform (4) ☐ Cannot perform at all (5)
Climbing stairs: ☐ Can perform with no difficulty (0) ☐ Can perform with little difficulty (1) ☐ Can perform with moderate difficulty (2) ☐ Can perform with great difficulty or need little assistance to perform (3) ☐ Cannot perform or require assistance to perform (4) ☐ Cannot perform at all (5)	**Eating:** ☐ Can perform with no difficulty (0) ☐ Can perform with little difficulty (1) ☐ Can perform with moderate difficulty (2) ☐ Can perform with great difficulty or need little assistance to perform (3) ☐ Cannot perform or require assistance to perform (4) ☐ Cannot perform at all (5)
Shopping: ☐ Can perform with no difficulty (0) ☐ Can perform with little difficulty (1) ☐ Can perform with moderate difficulty (2) ☐ Can perform with great difficulty or need little assistance to perform (3) ☐ Cannot perform or require assistance to perform (4) ☐ Cannot perform at all (5)	**Cooking:** ☐ Can perform with no difficulty (0) ☐ Can perform with little difficulty (1) ☐ Can perform with moderate difficulty (2) ☐ Can perform with great difficulty or need little assistance to perform (3) ☐ Cannot perform or require assistance to perform (4) ☐ Cannot perform at all (5)
House work: ☐ Can perform with no difficulty (0) ☐ Can perform with little difficulty (1) ☐ Can perform with moderate difficulty (2) ☐ Can perform with great difficulty or need little assistance to perform (3) ☐ Cannot perform or require assistance to perform (4) ☐ Cannot perform at all (5)	**Driving:** ☐ Can perform with no difficulty (0) ☐ Can perform with little difficulty (1) ☐ Can perform with moderate difficulty (2) ☐ Can perform with great difficulty or need little assistance to perform (3) ☐ Cannot perform or require assistance to perform (4) ☐ Cannot perform at all (5)

Managing Finances: ☐ Can perform with no difficulty (0) ☐ Can perform with little difficulty (1) ☐ Can perform with moderate difficulty (2) ☐ Can perform with great difficulty or need little assistance to perform (3) ☐ Cannot perform or require assistance to perform (4) ☐ Cannot perform at all (5)	Sleeping: ☐ Can perform with no difficulty (0) ☐ Can perform with little difficulty (1) ☐ Can perform with moderate difficulty (2) ☐ Can perform with great difficulty or need little assistance to perform (3) ☐ Cannot perform or require assistance to perform (4) ☐ Cannot perform at all (5)
Concentrating: ☐ Can perform with no difficulty (0) ☐ Can perform with little difficulty (1) ☐ Can perform with moderate difficulty (2) ☐ Can perform with great difficulty or need little assistance to perform (3) ☐ Cannot perform or require assistance to perform (4) ☐ Cannot perform at all (5)	Reading: ☐ Can perform with no difficulty (0) ☐ Can perform with little difficulty (1) ☐ Can perform with moderate difficulty (2) ☐ Can perform with great difficulty or need little assistance to perform (3) ☐ Cannot perform or require assistance to perform (4) ☐ Cannot perform at all (5)
Hobbies/Interests: ☐ Can perform with no difficulty (0) ☐ Can perform with little difficulty (1) ☐ Can perform with moderate difficulty (2) ☐ Can perform with great difficulty or need little assistance to perform (3) ☐ Cannot perform or require assistance to perform (4) ☐ Cannot perform at all (5)	Working: ☐ Can perform with no difficulty (0) ☐ Can perform with little difficulty (1) ☐ Can perform with moderate difficulty (2) ☐ Can perform with great difficulty or need little assistance to perform (3) ☐ Cannot perform or require assistance to perform (4) ☐ Cannot perform at all (5)
Caring for children/grandchildren: ☐ Can perform with no difficulty (0) ☐ Can perform with little difficulty (1) ☐ Can perform with moderate difficulty (2) ☐ Can perform with great difficulty or need little assistance to perform (3) ☐ Cannot perform or require assistance to perform (4) ☐ Cannot perform at all (5)	Caring for pets: ☐ Can perform with no difficulty (0) ☐ Can perform with little difficulty (1) ☐ Can perform with moderate difficulty (2) ☐ Can perform with great difficulty or need little assistance to perform (3) ☐ Cannot perform or require assistance to perform (4) ☐ Cannot perform at all (5)

Score: ____/100

CHIROPRACTIC REGISTRATION AND HISTORY

1. PATIENT INFORMATION
Date:_____
Patient Name:_____
Address:_____
City:_____
State:_____Zip:_____
Sex: ☐M ☐F Birthdate:_____
☐Married ☐Widowed ☐Single ☐Minor
Patient
Employer/School:_____
Occupation:_____
Employer/School Address:_____
_____
Employer/School Phone:
(_____)_____
Spouse's
Name:_____
Birthdate:_____
Spouse's
Employer:_____
Whom may we thank for referring you?_____

2. PHONE NUMBERS
Cell Phone
(_____)_____
Other
(_____)_____
Best time and place to reach you_____
IN CASE OF EMERGENCY, CONTACT
Name:_____
Relationship:_____
Phone
(_____)_____
Other
(_____)_____

3. ACCIDENT INFORMATION
Is condition due to an accident? ☐Yes ☐No
Type of accident
☐Auto ☐Work ☐Home ☐Other
Date of accident:_____
To whom have you made a report of your accident:
☐Auto Insurance
☐Employer
☐Worker Comp
Attorney Name:_____

4. PATIENT CONDITION
Reason for visit:_____

When did your symptoms appear?_____

Is this condition getting progressively worse? ☐Yes ☐No ☐Unknown

Mark an **X** on the picture where you continue to have pain, numbness, or tingling

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting

☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling ☐Other

How often do you have this pain?_____Is it constant or does it come and go?_____

5. HEALTH HISTORY

What treatment have you already received for your condition? ☐Medications ☐Surgery ☐Physical Therapy ☐Chiropractic Services ☐None ☐Other_____

Name and Address of other doctor(s) who have treated your condition_____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____
Spinal Exam_____ Chest X-Ray_____ Urine Test_____
Dental X-Ray_____ MRI, CT-Scan, Bone Scan_____

Check the following that you **HAVE** had:

AIDS/HIV	☐	Diabetes	☐	Liver Disease	☐	Rheumatic Fever	☐
Alcoholism	☐	Emphysema	☐	Measles	☐	Rheumatoid Arthritis	☐
Allergy Shots	☐	Epilepsy	☐	Migraines	☐	Scarlet Fever	☐
Anemia	☐	Fractures	☐	Miscarriage	☐	STD	☐
Anorexia	☐	Glaucoma	☐	Mononucleosis	☐	Stroke	☐
Appendicitis	☐	Goiter	☐	Multiple Sclerosis	☐	Suicide Attempt	☐
Arthritis	☐	Gout	☐	Mumps	☐	Thyroid Problems	☐
Asthma	☐	Heart Disease	☐	Osteoporosis	☐	Tonsillitis	☐
Bleeding Disorders	☐	Hepatitis	☐	Pace Maker	☐	Tuberculosis	☐
Breast Lump	☐	Hernia	☐	Parkinson's	☐	Tumors, Growths	☐
Bronchitis	☐	Herniated Disk	☐	Pinched Nerve	☐	Typhoid Fever	☐
Bulimia	☐	Herpes	☐	Pneumonia	☐	Ulcers	☐
Cancer	☐	High Blood Pressure	☐	Polio	☐	Vaginal Infections	☐
Cataracts	☐	High Cholesterol	☐	Prostate Problem	☐	Whooping Cough	☐
Chicken Pox	☐	Kidney Disease	☐	Prosthesis	☐		

Other:_____

Exercise:	Work Activity:	Habits:
☐None	☐Sitting	☐Smoking Packs/Day_____
☐Moderate	☐Standing	☐Alcohol Drinks/Week_____
☐Daily	☐Light Labor	☐Coffee/Caffeine Cups/Day_____
☐Heavy	☐Heavy Labor	☐High Stress Level Reason_____

Are you pregnant? ☐Yes ☐No Due Date_____

Injuries/Surgeries you have had	Description:	Date:
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications	Allergies	Vitamins/Minerals
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____