McCAFFREY™
HEALTH CENTER
revolutionizing healthcare

Patient Registration Form

Last Name: _____ First Name: _____ M.I.: _____

Mailing Address: _____ Apt #: _____

City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Social Security Number: _____ Sex: ☐M ☐F

Marital Status: ☐Single ☐ Married ☐ Divorced ☐ Widowed

Emergency Contact Name: _____ Phone Number: _____

Email Address: _____

Responsible Party – If the patient is a minor (under the age of 18), the parent or guardian bringing the patient, will be listed as the guarantor.

Last Name: _____ First Name: _____ M.I.: _____

Date of Birth: _____ Social Security Number: _____ Sex: ☐M ☐F

Address of Person Responsible: _____

City/State/Zip: _____

Insurance Information:

Ins. Co. Name: _____

Policy Holder Name: _____

Policy Holders Date of Birth: _____

Policy Holder Social Security Number: _____

Patient Relationship to Policy Holder: _____

Demographics updated ☐ Copy of Driver's License/ID ☐ Copy of Insurance Card ☐ Initials of Team Member _____

BASIC INFORMATION

FULL NAME: _____ TODAY'S DATE: __/__/____

DATE OF BIRTH: __/__/____

MAIN REASON YOU ARE COMING TO SEE OUR TEAM TODAY?

_____

_____

_____

CURRENT PHYSICAL CONDITION

WHAT IS (ARE) YOUR MAJOR CONCERN(S) ABOUT YOUR HEALTH? LIST THEM.

_____ _____ _____

_____ _____ _____

HOW ARE THESE HEALTH CONDITIONS/CONCERNS AFFECTING YOUR LIFE?

_____

_____

HOW LONG HAS IT BEEN SINCE YOU HAVE REALLY FELT GOOD?

_____

_____

GOALS AND EXPECTATIONS

IF YOU COULD CHANGE ONE THING ABOUT YOUR PHYSICAL HEALTH WHAT WOULD IT BE?

_____

_____

AND YOUR EMOTIONAL HEALTH?

_____

_____

AND YOUR NUTRITIONAL (CHEMICAL) HEALTH?

_____

_____

WHAT ARE YOUR EXPECTATIONS FROM OUR TEAM AT MCCAFFREY HEALTH CENTER?

_____

_____

WHAT ARE YOUR WELLNESS GOALS/EXPECTATIONS THAT YOU WOULD LIKE TO ACCOMPLISH?

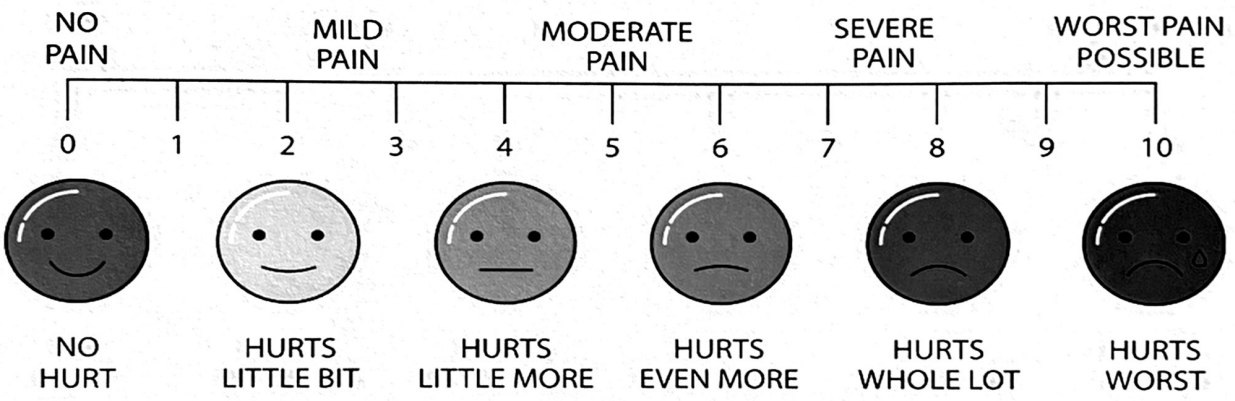
_____

_____

RATE YOUR PAIN CURRENTLY

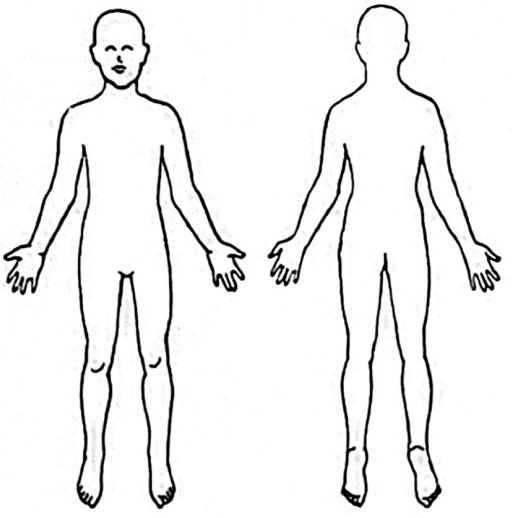
PLEASE CIRCLE NUMBER ON SCALE

PAIN MEASUREMENT SCALE



WHERE IS YOUR PAIN?

Describe your pain:
☐ Dull ☐ Ache ☐ Sharp ☐ Stabbing
☐ Pins & Needles ☐Shooting Pain
☐ Burning ☐ Throbbing
☐ Twinge ☐ Numbness/Tingling
☐ Other_____
Is your pain constant? ☐ Yes ☐ No
Intermittent? ☐ Yes ☐ No
Fluctuates with activity? ☐ Yes ☐ No
Wakes you up at night? ☐ Yes ☐ No



HEALTH HISTORY

CHECK ANY OF THE FOLLOWING CONDITIONS THAT APPLY TO YOU:

☐ ACNE ☐ DIABETES ☐ SINUS PROBLEMS ☐ ANEMIA

☐ DIFFICULTY BREATHING ☐ SKIN CONDITIONS ☐ ARTHRITIS

☐ EMPHYSEMA ☐ ULCERS/COLITIS

☐ ARTIFICIAL BONES/JOINTS ☐ FAINTING/SEIZURES

☐ ARTIFICIAL VALVES ☐ FREQUENT NECK/BACK PAIN

☐ ASTHMA ☐ GLAUCOMA ☐ CANCER

☐ HEART ATTACK/STROKE ☐ CHEMOTHERAPY

☐ HIGH BLOOD PRESSURE ☐ CHRONIC BAD BREATH

☐ LOW BLOOD PRESSURE ☐ CONGENITAL HEART DEFECT

☐ LYME DISEASE ☐ DEPRESSION

☐ SEVERE/FREQUENT HEADACHES

LIFESTYLE

CHECK MARK THOSE THAT APPLY TO YOU:

EXERCISE	*WORK ACTIVITIES*	*STRESS LEVEL*
☐ NONE	☐ MOSTLY SITTING	☐ NONE
☐ MODERATE	☐ MOSTLY STANDING	☐ LOW
☐ DAILY	☐ LIGHT LABOR	☐ MODERATE
☐ HEAVY	☐ HEAVY LABOR	☐ HIGH

Please list all prescribed medications, over the counter medications, herbals/vitamins & what you are taking them for:

MEDICATION:	REASON YOU ARE TAKING:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

STATEMENT OF UNDERSTANDING

I, _____, hereby declare that all information I provided is true and current to the best of my knowledge. I recognize McCaffrey Health Center's ability to provide the best care possible and give them permission to advise and treat me accordingly as well as obtain payment for the treatment to carry out its health care operations.

I also acknowledge that McCaffrey Health Center will keep all my information private according to the required Health Insurance Portability and Accountability Act (HIPAA) policy. The McCaffrey Health Center's Privacy Notice contains all guidelines to protecting my information and I am aware that I can request to read it at any time. It is provided at the front desk for my convenience. I acknowledge that McCaffrey Health Center reserves the right to change its privacy practices that are described in the Privacy Notice, in accordance with applicable law.

I have read and understand the foregoing notice and all my questions have been answered to my full satisfaction in a way that I understand it.

_____ _____/_____/_____

Patient name (please print) Today's date

_____ OR _____

Patient signature Signature of legal representative

INFORMED CONSENT FOR CARE

PATIENT NAME: _____

The nature of the chiropractic adjustment

- The primary treatment used by Doctor (s) of Chiropractic Care is spinal manipulative therapy. 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.

Analysis/Examination/Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

- Spinal manipulative therapy
- Vital signs
- Range of motion testing
- Postural analysis testing
- Acupuncture
- Nutrition
- Palpitation
- Neurological testing
- Muscle strength testing
- Orthotics
- Radiological studies
- Health and Wellness

Other: _____

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. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor 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 the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring

- Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray if necessary.

The risks and dangers attendant to remaining untreated

- Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer is postponed.

_____ _____/_____/_____

Patient name (please print) Today's date

_____ _____

Patient signature OR Signature of legal representative

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize **McCaffrey Health Center** to perform diagnostic test and render chiropractic adjustments and other treatment to my minor son/daughter: _____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) under the terms and conditions of my divorce, separation or other legal authorization, the consent of spouse/former spouse and/or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

By signing below, I state that I have weighed the risks involving in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. I hereby give my consent to be treated.

_____ _____/_____/_____

Patient name (please print) Today's date

_____ OR _____

Patient signature Signature of Parent or Guardian (if a Minor)

A. Notifier: MCCAFFREY HEALTH CENTER

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D. SEE BELOW**, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D. SERVICES** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
99201-99205 99211-99215 98940, 98941, 98942 AND 98943 989402-99412 95831 AND 95832 97760 97811 97112	MEDICARE DOES NOT PAY FOR THIS SERVICE GENERALLY	$750.00 $150.00 $55.00 $65.00 $150.00 $55.00 $65.00+10 $35.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. SERVICES** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D. SERVICES** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D. SERVICES** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D. SERVICES** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.