Patient Information

Date:_____

Patient Name _____

Address_____

City_____ State_____ Zip_____

Email_____

Home Phone_____

Cell Phone _____

Cell phone carrier _____

Work Phone _____Ext_____

What is the best time to contact you?_____

Sex: 0 M 0 F Age_____ Birth date_____

0 Single 0 Married 0 Widowed 0 Separated 0 Divorced

Patient SS#_____

Occupation_____

Employer_____

Employer Address_____

City_____ State_____ Zip_____

Employer Phone_____

Spouse's Name_____

Birthdate_____SS#_____

Occupation_____

Spouse's Employer_____

*Whom may we thank for referring you?*_____

_____

IN CASE OF EMERGENCY, CONTACT:

Name_____

Relationship_____

Home Phone_____

Alt. Phone_____ext_____

Insurance

Who is responsible and relationship to patient?_____

_____

Insurance Co._____

Policy No._____

Subscriber's Name_____

Birthdate_____SS#_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____ and sign directly to Dr. Mayer all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

Patient Condition

Reason for visit_____

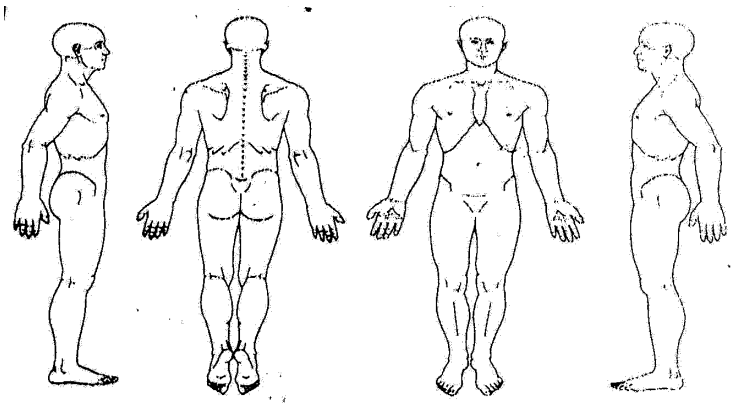
Describe your symptoms and _____

_____

When did your symptoms begin? _____

Is this condition getting worse? 0 Yes 0 No 0 Unknown

Indicate on the picture where you have pain, numbness, or tingling.



Rate the severity of your pain from 0 no pain to 10 severe

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10

Type of pain: 0 Sharp 0 Dull 0 Throbbing 0 Numbness

0 Aching 0 Shooting 0 Burning 0 Tingling 0 Cramps

0 Stiffness 0 Swelling 0 Other _____

How often is the pain during the day?

0 Constant (76-100%) 0 Frequently (51-75%)

0 Occasionally (26-49%)0 Intermittently (0-25%)

Does it interfere with 0 Work 0 Sleep 0 Daily Routine 0 Recreation

What activities or movements are painful to perform?_____

_____

What activities or movements make the pain better?_____

_____

Accident Information

Is this condition due to an accident? 0 Yes 0 No (date)_____

Type of accident 0 Auto 0 Work 0 Home 0 Other_____

To whom have you made a report of your accident?

0 Auto Insurance 0 Employer 0 Worker Comp. 0 Other

Attorney Name (if applicable)_____

Claim Number_____

Claim Address_____

City_____ State_____ Zip_____

Health History

What treatment have you already received for your condition? 0 Medications 0 Surgery 0 Physical Therapy 0 Chiropractic 0 None

0 Other _____

Name and phone number of other doctor(s) who have treated you for this condition _____

_____

What tests have you had done and when? X-Rays (date)_____ MRI (date)_____

CT Scan (date)_____ Other (date)_____

Do you have this information with you? Yes _____ No _____

For each condition listed below, place a check in the Past or the Present column if you have had the condition in the past or presently have one of the conditions listed below:

Past	Present		Past	Present	
O	O	Headaches	O	O	Recent Fever
O	O	Neck Pain	O	O	Diabetes
O	O	Upper Back Pain	O	O	High Blood Pressure
O	O	Mid Back Pain	O	O	Stroke (date) _____
O	O	Low Back Pain	O	O	Corticosteroid Use
O	O	Shoulder Pain	O	O	Birth Control Pills
O	O	Elbow/Upper Arm Pain	O	O	Dizziness/Fainting
O	O	Wrist Pain	O	O	Cancer/Tumor (explain) _____
O	O	Hand Pain	O	O	Hepatitis
O	O	Ankle/Foot Pain	O	O	Liver/Gall Bladder Disorder
O	O	Hip/Upper Leg Pain	O	O	Osteoporosis
O	O	Knee/Lower Leg Pain	O	O	Epilepsy/Seizures
O	O	Jaw Pain	O	O	Prostate Problems
O	O	Joint Swelling/Stiffness	O	O	Menstrual Problems
O	O	Arthritis	O	O	Urinary Problems
O	O	Rheumatoid Arthritis	O	O	Currently Pregnant (# weeks) __
O	O	Pain at Night	O	O	Visual Disturbances
O	O	Asthma	O	O	Kidney Problem (explain) _____
O	O	Allergies	O	O	Depression
O	O	Smoke (packs/day) __	O	O	Alcohol Consumption (drinks/ week) _____

Indicate if an immediate family member has had any of the following:

0 Rheumatoid Arthritis 0 Heart Problems 0 Diabetes 0 Cancer 0 Lupus 0 High Blood Pressure 0 Other _____

List all the prescription and over the counter medications, and nutritional/herbal supplements you are taking and respective timelines_____

_____

List all the surgical procedures you have had and times you have been hospitalized, and any other scars you may have and where they are located? _____

_____

_____

_____

What do you hope to get from your visit/treatment (select all that apply)

O Reduce your symptoms O Explanation of condition/treatment O How to prevent this from occurring again

O Resume/Increase activity O Learn how to take care of this on my own O Other _____

Patient Signature _____ **Date** _____

Signing above gives us permission to treat you starting from today until you finish your treatment plan.

PAIN RATING SCALE

Patient Name _____ Date _____

Instructions: Please choose the number which best describes your pain in each of the questions below.

1. What is your pain RIGHT NOW?

0	1	2	3	4	5	6	7	8	9	10
O	O	O	O	O	O	O	O	O	O	O

No Pain Unbearable Pain

2. What is your TYPICAL or AVERAGE pain?

0	1	2	3	4	5	6	7	8	9	10
O	O	O	O	O	O	O	O	O	O	O

No Pain Unbearable Pain

3. What is your pain AT ITS WORST?

0	1	2	3	4	5	6	7	8	9	10
O	O	O	O	O	O	O	O	O	O	O

No Pain Unbearable Pain

BACK INDEX

Patient Name _____ Date _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity
(0) The pain comes and goes and is very mild.
(1) The pain is mild and does not vary much.
(2) The pain comes and goes and is moderate.
(3) The pain is moderate and does not vary much.
(4) The pain comes and goes and is severe.
(5) The pain is very severe and does not vary much.

Sleeping
(0) I get no pain in bed.
(1) I get pain in bed, but it does not prevent me from sleeping well.
(2) Because of pain my normal sleep is reduced by less than 25%.
(3) Because of pain my normal sleep is reduced by less than 50%.
(4) Because of pain my normal sleep is reduced by less than 75%.
(5) Pain prevents me from sleeping at all.

Sitting
(0) I can sit in any chair as long as I like.
(1) I can only sit in my favorite chair as long as I like.
(2) Pain prevents me from sitting more than 1 hour.
(3) Pain prevents me from sitting more than ½ hour.
(4) Pain prevents me from sitting more than 10 minutes.
(5) I avoid sitting because it increases pain immediately.

Standing
(0) I can stand as long as I want without pain.
(1) I have some pain while standing, but it does not increase with time.
(2) I cannot stand for longer than 1 hour without increasing pain.
(3) I cannot stand for longer than ½ hour without increasing pain.
(4) I cannot stand for longer than 10 minutes without increasing pain.
(5) I avoid standing because it increases pain immediately.

Walking
(0) I have no pain while walking.
(1) I have some pain while walking, but it doesn't increase with distance.
(2) I cannot walk more than 1 mile without increasing pain.
(3) I cannot walk more than ½ mile without increasing pain.
(4) I cannot walk more than ¼ mile without increasing pain.
(5) I cannot walk at all without increasing pain.

Personal Care
(0) I do not have to change my way of washing or dressing in order to avoid pain.
(1) I do not normally change my way of washing or dressing even though it causes some pain.
(2) Washing and dressing increases the pain, but I manage not to change my way of doing it.
(3) Washing and dressing increases the pain and I find it necessary to change my way of doing it.
(4) Because of the pain I am unable to do some washing and dressing without help.
(5) Because of the pain I am unable to do any washing and dressing without help.

Lifting
(0) I can life heavy weights without extra pain.
(1) I can lift heavy weights, but it causes extra pain.
(2) Pain prevents me from lifting heavy weights off the floor.
(3) Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
(4) Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
(5) I can only lift very light weights.

Traveling
(0) I get no pain while traveling.
(1) I get some pain while traveling, but none of my usual forms of travel make it worse.
(2) I get extra pain while traveling, but it does not cause me to seek alternate forms of travel.
(3) I get extra pain while traveling which causes me to seek alternate forms of travel.
(4) Pain restricts all forms of travel except that done while lying down.
(5) Pain restricts all forms of travel.

Social Life
(0) My social life is normal and gives me no extra pain.
(1) My social life is normal, but increases the degree of pain.
(2) Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g. dancing, etc).
(3) Pain has restricted my social life and I do not go out very often.
(4) Pain has restricted my social life to my home.
(5) I have hardly any social life because of the pain.

Changing degree of pain
(0) My pain is rapidly getting better.
(1) My pain fluctuates, but overall is definitely getting better.
(2) My pain seems to be getting better, but improvement is slow.
(3) My pain is neither getting better or worse.
(4) My pain is gradually worsening.
(5) My pain is rapidly worsening.

Back Index Score ☐

NECK INDEX

Patient Name _____ Date _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity
(0) I have no pain at the moment.
(1) The pain is very mild at the moment.
(2) The pain comes and goes and is moderate.
(3) The pain is fairly severe at the moment.
(4) The pain is very severe at the moment.
(5) The pain is the worst imaginable at the moment.

Personal Care
(0) I can look after myself normally without causing extra pain.
(1) I can look after myself normally but it causes extra pain.
(2) It is painful to look after myself and I am slow and careful.
(3) I need some help but I manage most of my personal care.
(4) I need help every day in most aspects of self care.
(5) I do not get dressed, I wash with difficulty and stay in bed.

Sleeping
(0) I have no trouble sleeping.
(1) My sleep is slightly disturbed (less than 1 hour sleepless).
(2) My sleep is mildly disturbed (1-2 hours sleepless).
(3) My sleep is moderately disturbed (2-3 hours sleepless).
(4) My sleep is greatly disturbed (3-5hours sleepless).
(5) My sleep is completely disturbed (5-7 hours sleepless).

Lifting
(0) I can life heavy weights without extra pain.
(1) I can lift heavy weights, but it causes extra pain.
(2) Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
(3) Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
(4) I can only lift very light weights.
(5) I cannot lift or carry anything at all.

Reading
(0) I can read as much as I want with no neck pain.
(1) I can read as much as I want with slight neck pain.
(2) I can read as much as I want with moderate neck pain.
(3) I cannot read as much as I want because of moderate neck pain.
(4) I can hardly read at all because of severe neck pain.
(5) I cannot read at all because of neck pain.

Driving
(0) I can drive my car without any neck pain.
(1) I can drive my car as long as I want with slight neck pain.
(2) I can drive my car as long as I want with moderate neck pain.
(3) I cannot drive my car as long as I want because of moderate neck pain.
(4) I can hardly drive at all because of severe neck pain.
(5) I cannot drive my car at all because of neck pain.

Concentration
(0) I can concentrate fully when I want with no difficulty.
(1) I can concentrate fully when I want with slight difficulty.
(2) I have a fair degree of difficulty concentrating when I want.
(3) I have a lot of difficulty concentrating when I want.
(4) I have a great deal of difficulty concentrating when I want.
(5) I cannot concentrate at all.

Recreation
(0) I am able to engage in all my recreation activities without neck pain.
(1) I am able to engage in all my usual recreation activities with some neck pain.
(2) I am only able to engage in most of my usual recreation activities because of neck pain.
(3) I am only able to engage in a few of my usual recreation activities because of neck pain.
(4) I can hardly do any recreation activities because of neck pain.
(5) I cannot do any recreation activities at all.

Work
(0) I can do as much work as I want.
(1) I can only do my usual work but no more.
(2) I can only do most of my usual work but no more.
(3) I cannot do my usual work.
(4) I can hardly do any work at all.
(5) I cannot do any work at all.

Headaches
(0) I have no headaches at all.
(1) I have slight headaches which come infrequently.
(2) I have moderate headaches which come infrequently.
(3) I have moderate headaches which come frequently.
(4) I have severe headaches which come frequently.
(5) I have headaches almost all the time.

Neck Index Score ☐

CANCELLATION POLICY

In order to provide every patient with the very best care, we have a 24-hour cancellation policy. Our overall concern is that patients stay on track with their prescribed therapy and rehabilitative exercises.

We understand that there are occasions when an appointment has to be changed. You should reschedule that appointment for the same or next available day. **Failure to change an appointment with at least 24-hours notice will incur a $50 charge.** This represents our minimum visit fee.

Please understand, our goal is to get you well as quickly as possible and your appointments are scheduled specifically towards that goal. If your treatment needs to be put on hold, please speak with a staff member as soon as possible. It is our sincere hope that we'll never have to invoke this policy. Thank you for your cooperation.

*I have read and understand the cancellation policy as it has been outlined by Capitol Rehab of Richmond.

(Patient Name)	(Sign Name)	(Date)
(Capitol Rehab Witness)	(Sign Name)	(Date)

Capitol Rehab Privacy Disclosure

At Capitol Rehab, we; our business associates; and our affiliated companies respect your privacy and the confidentiality of your personal information. In order to safeguard your privacy, we enforce the following privacy principles and information practices:

We respect your privacy and information about you and handle your data with care. You have the right to review and correct your personal information. You may review your information and notify us of errors and omissions. We manage your personal information with care. We will call all numbers on file and leave messages regarding confirmation of your appointment or with questions regarding your account unless you check the box at the bottom of this page. If someone calls the office and inquires about you by name, we will give general information (EX: the patient is in the office). We collect and maintain information to administer our business, and to provide products, services and information of importance to you. We provide security safeguards in the handling and maintenance of your information to protect against risks such as loss, destruction, or misuse. We conduct periodic reviews to ensure proper handling and processing of your information. We do not sell individual information to unaffiliated third parties for marketing purposes. Our information exchanges are within our trusted circle of affiliates and business associates and are designed to deliver products, services, and information that are helpful to you. We require our business associates and affiliates to protect your privacy. We will enforce these principles and hold our business associates and affiliates accountable for protecting your privacy.

Initial: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and sign directly to Dr. Mayer all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Initial : _____

Billing Policies

Patients are responsible for providing complete, accurate and current billing and insurance information.

For your convenience, Capitol Rehab of Richmond, P.C. participates with most insurance plans. As a service to you, we will file the appropriate reimbursement claim forms to participating insurance carriers. You will be responsible for payment of deductibles and co-payments at the time of your visit. *Copayments and Deductibles are due at the time of service*.

Your insurance policy is a contract between you and your insurance company. You are financially responsible to Capitol Rehab of Richmond, P.C. for non-payment of any fees not covered by your insurance.

Initial: _____

For your convenience, payments are accepted in cash, check, Visa, MasterCard, or Discover.

_____ _____

Patient Signature Date

☐ Messages regarding my case/account should only be left at the following phone number(s):

_____

Patient Name: _____

Date of Birth: _____

Primary Care Physician (PCP): _____

PCP Phone Number: _____

PCP Practice Name: _____

PCP Address: _____

(Optional)
Specialist: _____

Specialist Phone Number: _____

Specialist Practice Name: _____

Specialist Address: _____

Payment Options

Thank you, for choosing us as your healthcare providers. We are committed to your treatment being successful. Please understand that the payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require that you agree to and sign prior to any treatment. Our fees are based upon reasonable and customary charges. Fees for a visit or new problem are higher than the routine follow up because more time is required to diagnose and treat a new problem than to follow up on an existing one. Capitol Rehab bills for each modality rendered at the time of service.

Our fee schedule is as follows:

New Patient Examination	225.00
Office Visit (includes spinal manipulation, manual therapy, and exercise therapy)	175.00
Home Management/Self Care	35.00
Electric muscle stimulation	25.00
Ultrasound	20.00
MISSED APPOINTMENT/LESS THAN 24 HOURS NOTICE	50.00

Insurance

As a courtesy to our patients, we will verify your insurance coverage and file your insurance claims. This is not a guarantee of payment and you are ultimately responsible for any balance, deductible and/or co-payments. Payment for your deductible, coinsurance, or co-pay is due at each visit. We do not participate with any HMOs or Medicare, but do participate with many other insurance plans. Please ask our staff for a list of these groups. We do not submit secondary insurance claims. As for Anthem Healthkeepers they do not cover exercise therapy or Self-care. This is the patient's responsibility to pay out of pocket for these services to receive the proper treatment. In addition to your copay, there may be a charge for these services (see fee schedule above).

Patient's Initials _____

Collections

Delinquent accounts that are turned over to a collection agency or our attorney will be assessed a collection fee in which the patient is also responsible for.

Patient's Initials _____

"I have read, understand and agree to the provisions of the Financial Policy"

Signed: _____
(Signature of Patient/Person financially responsible for bill)