

APPLICATION FOR CARE AT CROSSROADS CHIROPRACTIC

Today's Date: _____ Whom may we thank for referring you? _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____ Age: _____ Male Female

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Home Phone: _____ Mobile Phone: _____

Marital Status: Single Married Divorced Widowed Do you have insurance? Yes No

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ # of Children: _____ Ages of Children: _____

Name & Number of Emergency Contact: _____ Relationship: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to our office: **Primary:** _____

Secondary: _____ **Third:** _____ **Fourth:** _____

On a scale of 1 to 10, with 10 being the worst pain and 1 being the least, rate your above complaints by circling a number:

Primary or chief complaint:	1	2	3	4	5	6	7	8	9	10
Secondary complaint:	1	2	3	4	5	6	7	8	9	10
Third Complaint:	1	2	3	4	5	6	7	8	9	10
Fourth Complaint:	1	2	3	4	5	6	7	8	9	10

When did the problem(s) begin? _____ When is it at its worst? AM PM Overnight

How long does it last? Constant On and off throughout the day Comes and goes throughout the week

How did this injury happen? _____

Has this condition been treated by anyone in the past? Yes No If yes, when? _____

By whom? _____ How long under care? _____ Outcome? _____

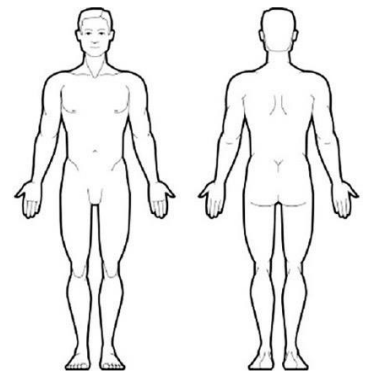
Please mark the areas on the diagram with the following letters to describe your symptoms:

R = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness **S** = Sharp/Stabbing **T** = Tingling

What relieves your symptoms? _____

What makes them feel worse? _____

List of Restricted Activities: _____ Normal Activity Level: _____ Current Activity Level: _____



Are there any other injuries to your spine, minor or major, that the doctor should know about? Yes No

If yes, please explain: _____

HISTORY

Have you suffered with this or similar problems in the past? Yes No If yes, how many times? _____

When was the last episode? _____ Did you try treatment? Yes No

If yes, what kind? _____ For how long? _____ Results? Favorable Not Favorable

Explain: _____

Please list any jobs you've had in the past that have exposed physical stress on your body:

If you have been diagnosed with any of the following, please indicate with a **P** for "in the Past" or a **C** for "currently have"

<input type="checkbox"/>	Broken Bone	<input type="checkbox"/>	Dislocations	<input type="checkbox"/>	Tumors	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	Fracture	<input type="checkbox"/>	Disability	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Osteoarthritis
<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Cerebral Vascular	<input type="checkbox"/>	Other Serious Condition:

Surgeries: _____ How long ago? _____ Type of care received: _____

Injuries: _____ How long ago? _____ Type of care received: _____

Childhood Disease: _____ How long ago? _____ Type of care received: _____

Adult Disease: _____ How long ago? _____ Type of care received: _____

SOCIAL HISTORY

Smoking Cigars Cigarettes Pipe How often? Daily Occasionally Never

Alcohol Consumption How often? Daily Occasionally Never

Recreational Drug Use: How often? Daily Occasionally Never

FAMILY HISTORY

Does anyone in your family suffer from the same condition(s)? Yes No

If yes, who? Grandfather Grandmother Father Mother Brother Sister Son Daughter

Any other hereditary conditions the doctor should be aware of? _____

I, the undersigned, attest that the answers given are true and accurate to the best of my knowledge. I hereby authorize payment to be made directly to Crossroads Chiropractic and Wellness Center for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize use of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Crossroads Chiropractic and Wellness Center for any and all services I receive at this office.

Patient Name (Please Print): _____

Patient or Authorized Person's Signature: _____ Date: _____

Doctor's Signature: _____ Date Forms Reviewed: _____

ACTIVITIES OF LIFE

Please identify with an "x" how your current condition is affecting your ability to carry out routine activities.

Carrying Groceries	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (can do)	<input type="checkbox"/>	Painful (limits)	<input type="checkbox"/>	Can Not Perform
Sit-to-Stand	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (can do)	<input type="checkbox"/>	Painful (limits)	<input type="checkbox"/>	Can Not Perform
Climbing Stairs	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (can do)	<input type="checkbox"/>	Painful (limits)	<input type="checkbox"/>	Can Not Perform
Pet Care	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (can do)	<input type="checkbox"/>	Painful (limits)	<input type="checkbox"/>	Can Not Perform
Driving	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (can do)	<input type="checkbox"/>	Painful (limits)	<input type="checkbox"/>	Can Not Perform
Extended Computer Use	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (can do)	<input type="checkbox"/>	Painful (limits)	<input type="checkbox"/>	Can Not Perform
Household Chores	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (can do)	<input type="checkbox"/>	Painful (limits)	<input type="checkbox"/>	Can Not Perform
Lifting Children	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (can do)	<input type="checkbox"/>	Painful (limits)	<input type="checkbox"/>	Can Not Perform
Reading/Concentration	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (can do)	<input type="checkbox"/>	Painful (limits)	<input type="checkbox"/>	Can Not Perform
Bathing	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (can do)	<input type="checkbox"/>	Painful (limits)	<input type="checkbox"/>	Can Not Perform
Dressing	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (can do)	<input type="checkbox"/>	Painful (limits)	<input type="checkbox"/>	Can Not Perform
Shaving	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (can do)	<input type="checkbox"/>	Painful (limits)	<input type="checkbox"/>	Can Not Perform
Sexual Activities	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (can do)	<input type="checkbox"/>	Painful (limits)	<input type="checkbox"/>	Can Not Perform
Sleep	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (can do)	<input type="checkbox"/>	Painful (limits)	<input type="checkbox"/>	Can Not Perform
Static Sitting	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (can do)	<input type="checkbox"/>	Painful (limits)	<input type="checkbox"/>	Can Not Perform
Static Standing	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (can do)	<input type="checkbox"/>	Painful (limits)	<input type="checkbox"/>	Can Not Perform
Yard Work	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (can do)	<input type="checkbox"/>	Painful (limits)	<input type="checkbox"/>	Can Not Perform
Walking	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (can do)	<input type="checkbox"/>	Painful (limits)	<input type="checkbox"/>	Can Not Perform

If you have experienced any of the below, please mark them with a "P" for "in the **past**" or a "C" for "**currently** have":

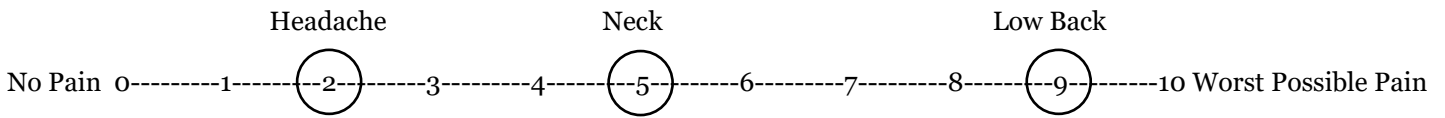
<input type="checkbox"/>	Headache	<input type="checkbox"/>	Pregnant	<input type="checkbox"/>	Painful Joints	<input type="checkbox"/>	Mood Changes
<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	Frequent Colds	<input type="checkbox"/>	Skin Problems	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Jaw Pain (TMJ)	<input type="checkbox"/>	Frequent Flu	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Low Blood Pressure
<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Loss of Balance	<input type="checkbox"/>	Prostrate Problems
<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Impotence
<input type="checkbox"/>	Mid Back Pain	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	Sexual Dysfunction
<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	Pain w/ Cough	<input type="checkbox"/>	ringing in Ears	<input type="checkbox"/>	Digestive Problems
<input type="checkbox"/>	Hip Pain	<input type="checkbox"/>	Foot Problems	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	Menopausal Problems
<input type="checkbox"/>	Back Curvature	<input type="checkbox"/>	Knee Problems	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Menstruation Problems
<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	Irritable	<input type="checkbox"/>	PMS
<input type="checkbox"/>	Learning Disability	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	Trouble Sleeping	<input type="checkbox"/>	Numb/Tingling Arms
<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	Numb/Tingling Hands
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	Lung Problems	<input type="checkbox"/>	Numb/Tingling Fingers
<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>	Liver Trouble	<input type="checkbox"/>	Hepatitis (A, B, C)	<input type="checkbox"/>	Numb/Tingling Legs
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	ADD / ADHD	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	Numb/Tingling Feet
<input type="checkbox"/>	Colon Trouble	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Numb/Tingling Toes

List any medications you take: _____

Please Read Carefully:

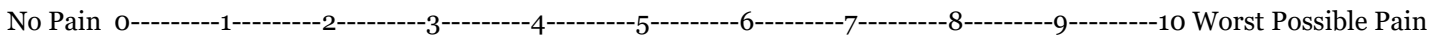
Instructions: Please circle the number that best describes the question being asked. If you have more than one complaint, please answer each question for each complaint, indicating the score for all complaints.

Example:

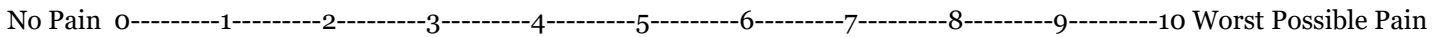


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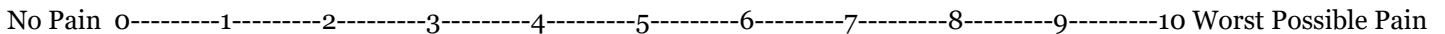
1. What is your pain RIGHT NOW?



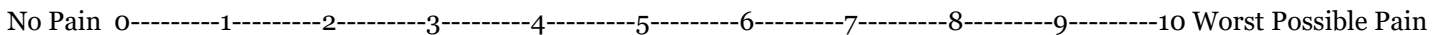
2. What's your TYPICAL or AVERAGE pain?



3. What is your pain level at its BEST (How close to "0" does it get at its best)?



4. What is your pain level at its WORST (How close to "10" does it get at its worst)?



OTHER COMMENTS:

What are your **TOP 3 HEALTH GOALS**?

1. _____

2. _____

3. _____

Informed Consent

Regarding: Chiropractic Adjustments, Modalities, and Therapeutic Procedures

Chiropractic care, like all forms of healthcare, holds certain risks. While the risks are most often very minimal, in rare cases complications such as sprain/strain injuries, irritation of disc condition and, although exceedingly rare, minor fractures and risk of stroke, which occurs at a rate of between 1 in 1 million to 1 in 2 million, have been associated with chiropractic adjustments.

I understand that the above list of items is not inclusive of all possible risks associated with chiropractic care and, after careful consideration, I do hereby consent to treatments by any means, method, and/or techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care, and I voluntarily assume all risks. I acknowledge that, like in all forms of healthcare, results are not guaranteed.

Patient or Authorized Person's Signature

Today's Date

Regarding: X-Rays/Imaging Studies

During your examination, the doctor may feel that x-rays will be needed in order to provide your treatment. Diagnostic x-rays provide the doctor with valuable information that cannot be evaluated otherwise.

I understand that modern digital x-ray equipment exposes patients to a very low dose of radiation. After careful consideration, I hereby consent to have the x-ray examination the doctor has deemed necessary for my case.

Patient or Authorized Person's Signature

Today's Date

FEMALES ONLY regarding the possibility of pregnancy

The first day of my last menstrual cycle was _____ (Date)

This is to certify that, to the best of my knowledge, I am **NOT** pregnant. The doctor and staff of Crossroads Chiropractic and Wellness Center have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

Female Patient or Authorized Person's Signature

Today's Date

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PERSUE PERSONAL INJURY, WORK COMP, ERISA,
AND OTHER LEGAL CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN
(INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE.

Provider Name: Dr. Mark Domanski
Clinic Name: Crossroads Chiropractic and Wellness Center
Clinic Address: 320 East Montgomery Crossroad, Suite 30, Savannah, GA 31406

I hereby assign to the above-named provider, hereinafter referred to as “my provider,” my designated authorized representative, all medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment directly to my provider for services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered and paid by insurance. I understand that I maintain responsibility for obtaining any required referrals, preauthorization, or any other applicable insurance coverage requirements.

I authorize the use of my signature on all insurance submissions and payments. In the event that any attorney, insurance company, or any other third party is obligated to make payment to me or to my provider, I hereby assign and transfer to my provider any cause of action or other legal right(s) which may exist on my behalf and expressly authorize my provider to litigate, compromise, settle or otherwise resolve such claim as my provider exclusively deems appropriate.

I hereby authorize my provider to release healthcare information to any attorney, insurance company, or any applicable third party which is necessary to facilitate payment under the terms of this agreement. I further authorize any such applicable party to release any information relevant to the processing of a claim for reimbursement directly to my provider or its authorized representative. Such information can include, but is not limited to, insurance contracts, plans, booklets, summaries or any other materials which I am legally entitled to receive.

I acknowledge and agree that this assignment of benefits and/or right to compensation for treatment shall not be rescinded or revoked by myself, my attorney or anyone who claims to represent me. I understand that I am responsible for all charges submitted for services rendered to me by my provider, and that payment by me is not contingent upon any settlement, judgment, or verdict which I may eventually obtain for payment of outstanding charges.

A photocopy of this assignment/agreement shall be considered as valid as the original. A photocopy of any insurance claim(s) shall also be valid and have the same effect as the original.

Patient or Authorized Person's Signature

Today's Date

NOTICE OF PRIVACY PRACTICE AND POLICIES

This office is required to notify you in writing that, by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information and the potential circumstances under which, by law or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Once you have read this notice and signed the following page, you are welcome to tear out this page and keep it for your records. Should you choose not to take this page, please review it thoroughly before leaving. The signature page following must be turned into the reception desk along with the rest of your paperwork

Permitted Disclosures:

1. Treatment purposed – discussion with other healthcare providers involved in your care
2. Inadvertent Disclosures – open treating areas mean open discussion. If you need to speak privately to the doctor, please let our staff know so that we can place you in a private consultation room.
3. For payment purposes – to obtain payment from your insurance company or any other collateral source
4. For workers compensation purposes – to process a claim or aid in investigation
5. Emergency – in the event of a medical emergency, we may notify a family member
6. For public health and safety – in order to prevent or lessen a serious or imminent threat to the health or safety of a person or persons or the general public.
7. To government agencies or law enforcement – to identify or locate a suspect, fugitive, material witness, or missing person.
8. For military, national security, prisoner and government benefits purposes
9. Deceased persons – discussions with coroners and medical examiners in the event of a patient’s death
10. Telephone calls or emails and appointment reminders – we may call your home and leave messages regarding missed appointments or apprise you of changes in practice hours or upcoming events.
11. Change of ownership – in the event this practice is sold, the new owners would have access to your PHI

Your rights:

1. To receive an accounting of disclosures
2. To request mailings to an address different than residence
3. To request restrictions on certain uses and disclosures and to whom we release information, although we are not required to comply. If we agree, the restriction will be in place until we receive written notice of your intent to remove the restriction.
4. To request amendments to information. However, like restrictions, we are not required to agree to them.
5. To obtain one (1) copy of your records, timely notice (72 hours) is required. Copying and postage fees may apply.

Refunds and Cancellation Policy:

Requests for refunds must be submitted in writing and will be reviewed upon receipt. If a refund is payable, it will be processed and a credit will be applied to your credit card or paid by check within 30 days of request.

In situations where insurance has been applied: A quote of benefits is not a guarantee of payment. Your claim will process according to your plan. If your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received. Once processed and applied, any refund will be issued in accordance with our refund policy.

Cancellation of a care plan negates extended discounts, and our standard office fee schedule will be applied to all services rendered. You are expected to do therapies (traction, rehab, wobble chair, vibration plate, etc.) when and as instructed. Should you choose to skip any or all therapies during a visit to the office, you must inform the front desk receptionist before leaving the office.

Returns and Exchanges:

Home Care Kits will not be eligible for refund, exchange, or credit.

Complaints:

If you wish to make a formal complaint about how we handle your health information, please call the office at 912-353-7611 to make an appointment to speak to the appropriate person.

Crossroads Chiropractic and Wellness Center
NOTICE OF PRIVACY PRACTICE AND POLICIES continued

I have received a copy of Crossroads Chiropractic and Wellness Center's NOTICE OF PRIVACY PRACTICE AND POLICIES. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights to the doctor. I further understand that this office reserves the right to amend this NOTICE OF PRIVACY PRACTICE AND POLICIES at any time in the future and will make the provisions effective for all information that it maintains, past and present.

I understand that I have been given the opportunity to discuss any of my concerns and questions about this notice and the privacy of my healthcare information.

Patient Name (Please Print Clearly): _____

Patient Date of Birth: _____

Patient or Authorized Person's Signature

Today's Date

Witness Signature

Today's Date

Crossroads Chiropractic and Wellness Center
Automobile Accident or Work Comp Questionnaire

Patient Name: _____

Date of Birth: _____

This information is considered confidential. Your answers will help us to determine if chiropractic care can help your condition. We will not accept your case if we do not believe your condition will respond satisfactorily to care. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form.

Date of Accident: _____

Time of Accident: _____

Were you the driver or passenger? _____

Were you Wearing Seatbelt? Yes No

What road were you on? _____

Were you at a complete stop? Yes No

Describe what happened: _____

Did you lose consciousness? Yes No

Did your airbags deploy? Yes No

Did you go to the ER? Yes No

If yes: Which hospital? _____

By Ambulance? Yes No

Did they take X-Rays? Yes No CT Scan? Yes No

What meds, if any, did they prescribe? _____

Have you seen any other doctors for this condition? Yes No If yes, who? _____

Where did you feel pain immediately following the accident? _____

List the extent of your injuries as you know them: _____

Have you ever had any problems in the involved areas prior to this accident? Yes No

If yes, what were your prior symptoms? _____

Before this injury, were you capable of working on an equal basis with others your age? Yes No

Are your work activities restricted as a result of this accident? Yes No

Since the accident, are your symptoms ... Improving? Getting Worse? Same?

Crossroads Chiropractic and Wellness Center
Automobile Accident or Work Comp Questionnaire continued

Patient Name: _____

Date of Birth: _____

Please mark any symptoms you've noticed since the accident that were not present prior to the accident:

<input type="checkbox"/> Headache	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Depression	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Light bothers eyes	<input type="checkbox"/> Buzzing in ears	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Neck pain
<input type="checkbox"/> Head feels heavy	<input type="checkbox"/> Memory loss	<input type="checkbox"/> Cold Feet	<input type="checkbox"/> Neck stiff
<input type="checkbox"/> Pins and Needles in arms	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Cold hands	<input type="checkbox"/> Fainting
<input type="checkbox"/> Sleeping problems	<input type="checkbox"/> Back pain	<input type="checkbox"/> Flushed face	<input type="checkbox"/> Loss of balance
<input type="checkbox"/> Pins and needles in legs	<input type="checkbox"/> Constipation	<input type="checkbox"/> Tension	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Numbness in fingers	<input type="checkbox"/> Loss of smell	<input type="checkbox"/> Fever	<input type="checkbox"/> Irritability
<input type="checkbox"/> Numbness in toes	<input type="checkbox"/> Loss of taste	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Cold sweats
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Upset stomach	<input type="checkbox"/> Other (specify): _____	_____

Attorney Involvement:

With regard to this accident, have you retained an attorney? Yes No

If yes: Attorney's Name: _____ Phone #: _____

Law Firm Name: _____

Attorney's Address: _____

Driver of the vehicle in which you were injured:

Name: _____

Relationship (circle one): Self Family Friend Other

Insurance Company: _____

Policy #: _____

Name of Adjuster: _____

Phone #: _____

Driver of other vehicle:

Name: _____

Claim #: _____

Insurance Company: _____

Policy #: _____

Name of Adjuster: _____

Phone #: _____

Patient or Authorized Person's Signature

Today's Date