



# Back 2 Back Chiropractic, PLLC

www.back2back.com

Cass City - Caseville

### WELCOME TO OUR OFFICE!

The doctors at Back 2 Back Chiropractic welcome you and want to provide you with the best possible care.

### INSURANCE

This office will process your insurance forms upon request. We will do our utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that, in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full.

**All fees are due at the time of service. This office accepts cash, check and credit card.**

**If this visit is WORK or AUTO related, please notify the front desk**

_____	Telephone _____
Your Name _____	Home _____
_____	Work _____
Primary Address _____	Cell _____
_____	
City, State and Zip _____	Preferred Language: _____
Date of Birth _____	Email: _____@_____
Sex:    MALE    FEMALE	Age _____ yrs    Height ____ ft ____ in
Race: White    Latino	Weight _____ lbs    Right / Left Handed
African American    Other: _____	Occupation: _____
<u>Marital Status:</u>	Employer: _____
Married    Single    Divorced    Widow	Is this visit work-related?    Yes    No
Social Security: _____ - _____ - _____	
Emergency Contact, Name & Number: _____	

### Name and DOB of the insured (name on the card, if not you):

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Relationship to you (Spouse, parent): \_\_\_\_\_

Who is the insurance through? (**Employer Name**, Medicare, Medicaid, other): \_\_\_\_\_

### How did you hear about us? (please indicate)

Friend     Family     Advertisement     Phone Book     Internet     Doctor  
 Other (please list): \_\_\_\_\_

It is *your* responsibility to know your coverage benefits, co-pays and deductible. Much of this information can be found by calling your carrier or by reading the EOBs that you receive from your carrier following service. If you receive a statement from this office and you feel there is an error, please do not hesitate to give us a call.

**Back 2 Back Chiropractic, PLLC  
INFORMED CONSENT & PRIVACY NOTICE**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me or on the patient named below, for whom I am legally responsible.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of the spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptoms, disease or condition as a result of treatment in the clinic. I understand that the chiropractor will use his or her hands or a mechanical device upon my body to adjust a joint, which may cause an audible “pop” or “click.” It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he or she feels at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor’s interpretation thereof, as well as the doctor’s judgment and expertise in working with similar cases.

I have an opportunity to discuss the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited, fractures, disc injuries, strokes, dislocation and sprains.

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health, history, symptoms, examination and test, diagnosis, treatment, and any part for future care or treatments. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided. I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I’ve provided or forward a copy in via- e-mail at my request. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have a right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already take action in reliance thereon.

I have read, or have had read to me, the Informed Consent to Chiropractic Adjustments and Care. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above – named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

**Assignment of Insurance Benefits**

I authorize and direct that payment be made directly to:

**Vollmar-Yeager Chiropractic, PLLC  
DBA Back 2 Back Chiropractic, PLLC  
4456 Seeger Street Cass City, MI 48726**

for any and all insurance benefits or reimbursement for services rendered by him/her which amounts would otherwise be payable to me under any insurance or pre-paid health care plan. I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan or Medicare. **I understand that there is no guarantee that my insurance company(s) or pre-paid health plan, including Medicaid, will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges designated as patient responsibility. This office reserves the right to assess/collect monthly late fees for any unpaid balance exceeding 30 days after the last date of service. In the event the account becomes delinquent, we reserve the right to incorporate any fees for recovering the owed amount.**

Sign below to acknowledge the above:

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Authorization for the Release of Protected Health Information to:**

**Back 2 Back Chiropractic, PLLC  
4456 Seeger St, Cass City, MI 48726  
Phone 989-872-2737 Fax 989-872-2740**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**I request and authorize the entities and individuals listed above to release my protected health information and send to Back 2 Back Chiropractic, PLLC.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**MASSAGE CANCELLATION POLICY:**

*All massages require cancellation 24 hours in advance. Failure to do so will result in a \$30 fee applied to the client's account.*

*Initial to acknowledge:* \_\_\_\_\_

**Health History – Tell Us About Your Health**

**Have you ever been diagnosed with the following: (Please Circle)**

- |                   |                      |                  |
|-------------------|----------------------|------------------|
| AID/HIV           | High Blood Pressure  | Stroke           |
| Anxiety           | High Cholesterol     | Thyroid Problems |
| Arthritis         | Kidney Disease       | Tuberculosis     |
| Bleeding Disorder | Liver Disease        | Tumors/Growths   |
| Breast Lump       | Migraines            | Other: _____     |
| Cancer            | Multiple Sclerosis   | _____            |
| Diabetes          | Mononucleosis        | _____            |
| Depression        | Osteoporosis         | _____            |
| Epilepsy          | Pacemaker            | _____            |
| Gout              | Pinched Nerve        | _____            |
| Heart Disease     | Polio                |                  |
| Hepatitis         | Prostate Problem     |                  |
| Herniated Disc    | Rheumatoid Arthritis |                  |

Do you have any **allergies** to **medication** or **food**? **Y / N WHAT?:** \_\_\_\_\_

**Family History – Tell Us About Your Family's Health**

**Does anyone in your family suffer from: (Please Circle)**

- |                      |                              |
|----------------------|------------------------------|
| High blood pressure  | Stroke                       |
| Diabetes             | Circulation Problems         |
| Cancer               | Autoimmune disease           |
| Thyroid disease      | RA/Lupus/Reynauds/Psoriasis) |
| Osteoporosis         | Digestive Problems           |
| Rheumatoid arthritis | Lung Disease                 |
| Heart Problems       | Back Pain                    |
| Kidney Disease       | Neck Pain                    |

**Review Of Systems –Tell Us About Your Body Systems**  
**Please circle any problems you have had in the past 6 months**

**Muscles/Skeleton**

- Lower Back Pain
- Neck Pain
- Joint Pain
- Stiffness
- Walking Problems

**Nervous System**

- Numbness
- Paralysis
- Dizziness /Confusion
- Tingling in Leg/Arm
- Stress

**General**

- Headaches
- Loss of Sleep

Fever

**Gastrointestinal**

- Excessive Thirst
- Vomiting
- Diarrhea / Constipation
- Gall Bladder Trouble
- Abdominal Cramps
- Heartburn
- Black/Bloody Stools
- Bowel Trouble

**Urinary**

- Bladder Trouble
- Painful Urination
- Frequent Urination
- Discolored Urine

**Heart/Lungs**

- Chest Pain
- Shortness of Breath
- High Blood Pressure
- Heart Problems
- Ankle Swelling

**Eyes, Ears, Nose & Throat**

- Vision Trouble
- Dental Trouble
- Earaches
- Hearing Difficulty
- Sore Throat

**Social History – Tell Us About Your Everyday Life**

Do you drink Alcohol? Y / N

How Often? \_\_\_\_\_drinks/week

Do you use Tobacco? Y / N How many packs/day? \_\_\_\_\_ How Long? \_\_\_\_\_

If you have quit either, how long ago? \_\_\_\_\_y/m/d

Do you use cocaine, marijuana or other drugs? Y / N What? \_\_\_\_\_

Do you exercise? Y / N Type: Walking Running Swimming Biking Weights Aerobics

Other \_\_\_\_\_ How Often? \_\_\_\_\_ times per week for \_\_\_\_\_ minutes

Are you currently employed? Y / N

If NO, are you: Retired Unemployed Disabled Home-Maker Other

Where? \_\_\_\_\_ Address: \_\_\_\_\_

What do you do? \_\_\_\_\_ How Long? \_\_\_\_\_

Is the reason for this visit Work or Auto Accident related? Y / N \_\_\_\_\_

**If the problem you are seeking treatment for is work-related or auto-accident related, you must fill out a form related to the incident. Please ask the front desk.**

**Medications**

**Please list medications, supplements, herbs or other substances you are taking**


**Trauma and Surgery History**

**Please list most recent first. List Date, What Happened and Outcome**

**Example: 4/1/2010 Total hip replacement Good results**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Main Complaint**

The main problem is \_\_\_\_\_

The pain is on the right / left / middle / both sides of the \_\_\_\_\_

The pain first started: \_\_\_\_\_

It began: Gradually Suddenly After Trauma/Injury

What Happened? \_\_\_\_\_

What makes your symptoms worse? Standing, walking, sitting, bending, coughing, sneezing, other: \_\_\_\_\_

What makes your symptoms better? Ice, heat, pills, sitting, standing, other: \_\_\_\_\_

My pain feels (circle any): dull sharp achy numb tingling burning shooting

Does the pain or numbness travel to another area? (e.g.: down arm or leg) \_\_\_\_\_

How often is the pain present? Constantly intermittently occasionally frequently

If this is a recurrence, how long does it generally last? hours days weeks months years

Circle Pain Level (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

**Additional Complaint**

My second problem is \_\_\_\_\_

The pain is on the right / left / middle / both sides of the \_\_\_\_\_

The pain first started: \_\_\_\_\_

It began: Gradually Suddenly After Trauma/Injury

What Happened? \_\_\_\_\_

What makes your symptoms worse? Standing, walking, sitting, bending, coughing, sneezing, other: \_\_\_\_\_

What makes your symptoms better? Ice, heat, pills, sitting, standing, other: \_\_\_\_\_

My pain feels (circle any): dull sharp achy numb tingling burning shooting

Does the pain or numbness travel to another area? (e.g.: down arm or leg) \_\_\_\_\_

How often is the pain present? Constantly intermittently occasionally frequently

If this is a recurrence, how long does it generally last? hours days weeks months years

Circle Pain Level (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

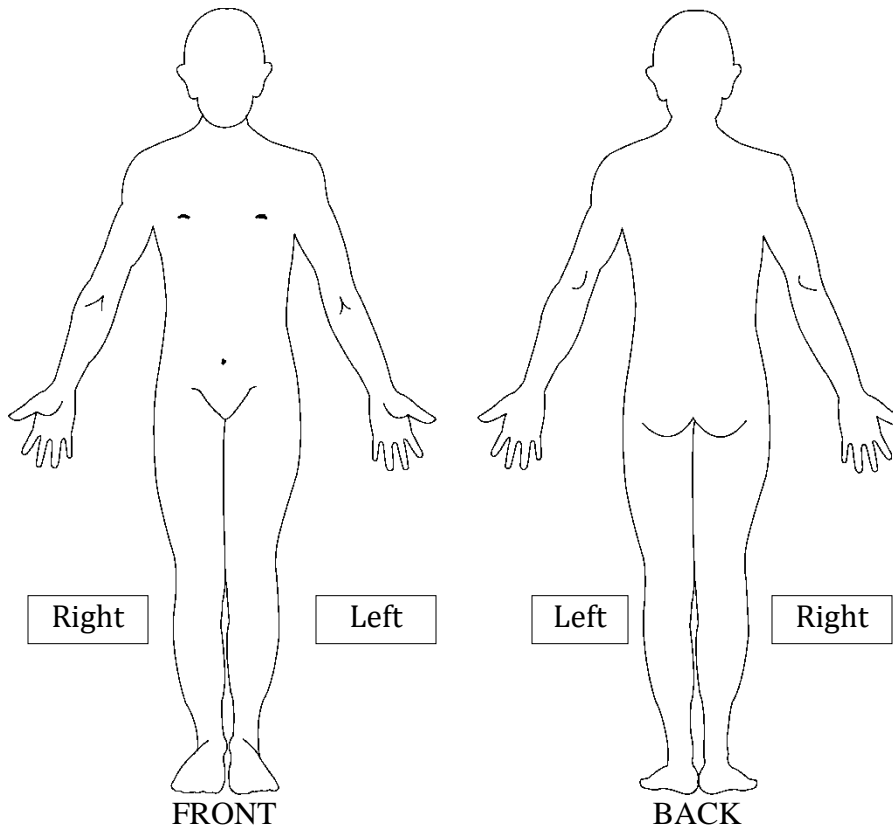
**WHERE DOES IT HURT?**

If you have more than one complain, number them by severity (1= biggest problem, 2= next worst problem, etc)

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	00000	xxxxx	*****	/////

Please mark on the pain scale from Zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.



**Neck/Shoulder Pain**

On a scale of zero to 10, I rate my discomfort as follows:  
 ( \_\_\_\_\_ )  
**0** **10**  
 no pain severe pain

**Middle Back Pain**

On a scale of zero to 10, I rate my discomfort as follows:  
 ( \_\_\_\_\_ )  
**0** **10**  
 no pain severe pain

**Low Back/Leg Pain**

On a scale of zero to 10, I rate my discomfort as follows:  
 ( \_\_\_\_\_ )  
**0** **10**  
 no pain severe pain

List any other symptoms:

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