WELCOME TO ZIVKOVIC CHIROPRACTIC CENTER

DATE:_____ **Please print clearly and fill in completely.**

ABOUT YOU:

Patient Name:_____ Email:_____ □ Male □ Female
What do you prefer to be called:_____ SS# _____
Street Address_____ City_____ State_____ Zip_____
Date of Birth:_____ Age:_____Who referred you to us?_____
Phone #: Home_____Work_____Cell_____
Status: □minor □single □married □ divorced □ separated □ widowed
Employer:_____ How long?_____ Occupation:_____
Spouses name:_____Do you have children? □yes □ no How many?_____

HISTORY:

Reason for seeking chiropractic care:_____
Describe any health problems, including how long you have had them:

_____

_____

Describe the pain and it's location:_____
When did condition begin?___/___/___
Is the condition getting worse? □yes □ no □constant □ comes and goes
Is this condition interfering with your (circle) work, sleep or daily routine.
Explain_____
Have you had the same or similar conditions in the past? □yes □ no
Explain_____
Have you been treated by a medical physician for this condition? □yes □ no Where_____

CHIROPRACTIC HISTORY:

Have you ever been to a chiropractor before?□yes □no If yes, doctor's name_____
Date of last chiropractic visit_____Reason for care_____
Date of last chiropractic x-rays_____How long were you under care?_____
Are other family members under chiropractic care? □yes □ no Who?_____

WELLNESS COMMITMENT:

At this chiropractic office we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We do not ask for a financial commitment, but we do ask for your cooperative commitment. Based on a scale of 10% to 100% please circle your personal level of commitment toward obtaining and maintaining wellness.

10%-----20%-----30%-----40%-----50%-----60%-----70%-----80%-----90%-----100%

For Females: Are you taking birth control? □yes □ no
Are you Pregnant? □yes □ no / How far long?_____ Nursing? □yes □ no

IN EVENT OF EMERGENCY:

Contact:_____ Relation:_____
Home phone:_____Work or Cell phone:_____

HEALTH HISTORY:

Current Weight _____lbs. Current Height _____ft. _____in.

Are you taking any of the following medications?

□Nerve pills□ pain killers □muscle relaxers □stimulants □blood thinners □ insulin □tranquilizers □other(s)_____

Do you have or have you had any of the following?

Y N Heart Attack/Stroke	**Y N Heart Surg/Pacemaker**	**Y N Heart Murmur**
Y N Congenital Heart Defect	**Y N Mitral Valve Prolapse**	**Y N Artificial Valves**
Y N Alcohol/ Drug Abuse	**Y N Venereal Disease**	**Y N Hepatitis**
Y N HIV+/Aids	**Y N Shingles**	**Y N Cancer**
Y N Frequent Neck Pain	**Y N Emphysema/ Glaucoma**	**Y N Anemia**
Y N High/Low Blood Pressure	**Y N Psychiatric Problems**	**Y N Rheumatic Fever**
Y N Frequent Headaches	**Y N Kidney Problems**	**Y N Ulcers/ Colitis**
Y N Seizures/Epilepsy	**Y N Sinus Problems**	**Y N Asthma**
Y N Diabetes/ Tuberculosis	**Y N Difficulty Breathing**	**Y N Chemotherapy**
Y N Lower Back Problems	**Y N Artificial Bones/ Joints**	**Y N Arthritis**
Y N Fainting	**Y N Insomnia**	**Y N Digestive Problems**

Please list any other serious medical condition (s) you have or ever had:_____

_____

List anything you may be allergic to:_____

List previous surgeries/ treatments with dates:_____

_____

List any past accidents with dates:_____

_____

List any x-rays you have had in the past 2 years:_____

Family Health History:_____

Do you take supplements or vitamins?□yes □no Exercise □yes □no special diet? □yes □ no

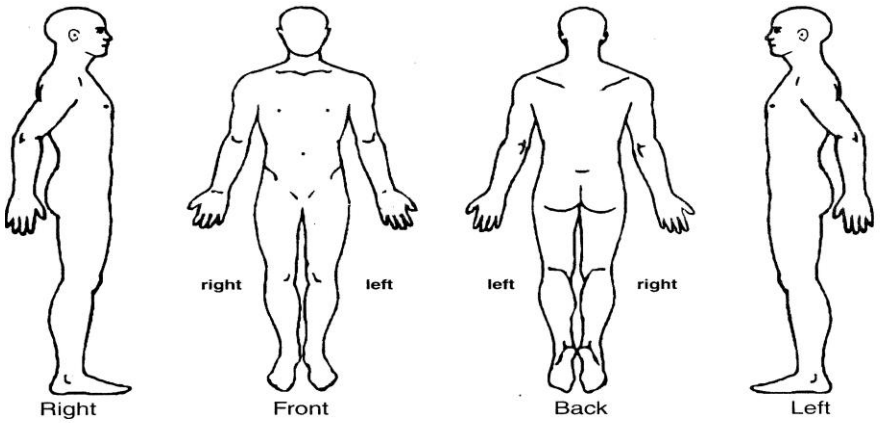
Do you smoke □yes □no How much?____ How long?____ How old is your mattress?_____

Is it comfortable?□yes □no Do you wear □Heel Lifts □Sole Lifts □Inner soles □Arch supports

SHOW US WHERE IT HURTS:

Mark areas of injury or discomfort with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description-	**Numbness**	**Pins & Needles**	**Burning**	**Aching**	**Stabbing**
Symbol-	**NNNN**	**PPPP**	**BBBB**	**AAAA**	**SSSS**



INSURANCE INFORMATION: Insurance Company name:____________________________
Address________________________________Phone#___________________________________
InsuredSS#____________________ID#__________________________Group#______________
Insured's Name:_____________________________________ Relation:_____________________
Insured's Date of Birth: ___/___/____ Insured's Employer_______________________________

ACCOUNT INFORMATION: Person ultimately responsible for account
Name:_____________________________ Relation:__________________________
Billing Address:____
SS#:________________________________ D.L. # __________________________
Work Phone# ____________________ Cell Phone#__________________________

Payment Method: □CASH □ CHECK □CREDIT CARD

______ (initials) I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

- **We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between the provider and the patient.**
- **Our office policy requires payment in full for all services rendered at the time of visit, unless prior arrangements have been made with the office manager. If account is not paid within 90 days from the date of service and no arrangements have been made, I understand I am responsible for legal fees, collection agency fees and any other expenses incurred in collecting my account .**
- **I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release information required to process insurance claims.**
- **I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information that I have provided.**

Signature____ Date ____/____/____

****

If patient is under the age of 18 this portion needs to be filled out

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize Dr. Zivkovic and whomever he/she may designate as assistant to administer treatment as he/she so deems necessary to my son/ daughter, ___________________________
Date:_____________________

Parent/ Guardian- Print & Sign:____

Witness/ Office staff:____
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ZIVKOVIC CHIROPRACTIC CENTER
DR. ANNETTE ZIVKOVIC DR. ROBERT ZIVKOVIC
We're Working Together For Your Health.

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. This level of risk is most often very minimal, yet in extremely rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain strain injuries, irritation of a disc condition, and, rarely, fractures. One of the rarest complications associated with chiropractic care—occurring at a rate between one instance per one million to one instance per two million-is the instance of cervical spine (neck) adjustments being applied to a pre-existing vertebral artery injury that could result in stroke.
Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessments.

_____ _____

Patient Name (Printed) **Date**

_____ _____

Patient or Legal Guardian Signature **Relationship to Patient**

_____ _____

Witness Signature (Office Staff) Date

*****FINANCIAL POLICY*****

OUR OFFICE POLICY IS THAT FEES ARE DUE WHEN SERVICES ARE RENDERED

PLEASE INITIAL LINES 1-5 AND SIGN THE BOTTOM AFTER YOU HAVE READ AND UNDERSTAND THEM ALL.

We will gladly discuss the cost of your visit and do our best to answer any questions related to payments or insurance. However, you must realize that:

1. **_____ If you have any insurance that you would like us to file, you must provide the benefit information and any forms to the receptionist prior to treatment. Please check with the receptionist to assure that we are contracted providers for your insurance.**
2. **_____ If you choose to use any form of insurance, you will be responsible for any claims that are not paid within 90 days. WE DO NOT FILE SECONDARY INSURANCE. We will be happy to run a receipt of each visit for you to send to your secondary insurance.**
3. **_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.**
4. **_____ I do hereby agree to pay for any treatment at the time of visit and that I will be held responsible for the balance of my account.**
5. **_____ I understand the methods of payment accepted are credit cards, checks and cash. If payment is returned for insufficient funds, a fee of $ 25.00 will be charged.**

Signature:_____ Date:_____

WE MUST EMPHASIZE AS YOUR HEALTH CARE PROVIDER, OUR RELATIONSHIP AND CONCERN IS WITH YOU AND YOUR HEALTH, NOT YOUR INSURANCE COMPANY.

ZIVKOVIC CHIROPRACTIC CENTER

DR. ANNETTE ZIVKOVIC DR. ROBERT ZIVKOVIC

We're Working Together For Your Health

DOCTOR/ PATIENT RELATIONSHIP IN CHIROPRACTIC

CHIROPRACTIC:

It is important to recognize the difference between chiropractic and medicine. Either can be important to your health, but for entirely different reasons. Chiropractors seek to restore health through natural means and without the use of medicine or surgery. Although a medical diagnosis may be of great importance to a patient, such diagnosis does not necessarily assist the chiropractor in his efforts. The chiropractor's purpose is to restore health through the natural flow of energy in the nervous system. This gives the body maximum opportunity to heal itself. The success of the Chiropractic procedures often depends upon underlying causes and conditions. It is important to understand what to expect from chiropractic and medical services in order that you, the patient, can determine whether either or both may be of benefit to you.

ANALYSIS:

A chiropractor conducts a chiropractic analysis for the express purpose of determining whether there is evidence of spinal subluxation. When such subluxations are found, Chiropractic adjustments are given to restore spinal alignment. It is the chiropractor's premise that proper spinal alignments allows free nerve flow throughout the body and gives the body its best chance to restore health. Due to the complexities of nature, no chiropractor can promise you specific results. This depends upon the recuperative powers of the body.

DIAGNOSIS:

Although chiropractors are experts in chiropractic analysis, they are not specialists in the field of diagnosis. Internists are medical specialists who are highly qualified to diagnosis. Every chiropractic patient should be mindful of his own symptoms and should secure medical opinion if he has any concern as to the nature of his illness or injury. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you should take the initiative if in doubt.

CHIROPRACTIC ADJUSTMENTS:

The patient, in coming to the chiropractic gives the chiropractor permission and authority to adjust the patient in accordance with the chiropractic analysis. The chiropractic adjustment is usually beneficial and seldom causes any problem. In rare cases underlying physical defects, deformities, or pathology may render the patient susceptible to injury. The chiropractor of course, will not give a chiropractic adjustment if he is aware that such conditions exist. Again, it is the responsibility of the patient to make it known, to learn through medical procedures whether he is suffering from latent pathological defects illness or deformity which otherwise would not come to the attention of the chiropractor. The patient should not look to the Doctor of Chiropractic for indepth diagnosis procedures. The Doctor of Chiropractic provides a specialized health service, does not and should not become involved in the patient's medical regimen. A patient should never ask or accept advice from a chiropractor concerning the taking of prescriptive medicines. The Doctor of Chiropractic is not licensed in medical practices.

RESULT:

The purpose of chiropractic services is to promote natural health through the release of maximum nervous energy. Since there are so many variables, it is difficult to predict the time schedule and efficiency of chiropractic procedures. Sometimes the response is phenomenal, In some cases, there is more gradual, but quite satisfactory response. Occasionally, the results are mediocre or dismal. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions, which do not respond chiropractic care, may come under control or be better treated through medical science. The fact is, the sciences of chiropractic and medicine may never be so exact as to provide definite answers to many problems. Both have made great strides in alleviating pain and controlling disease.

The patient should discuss any questions or problems with the doctor before signing this statement of policy.

ACKNOWLEDGEMENT:

I HAVE READ THE FOREGOING AND UNDERSTAND IT. Signed this day of _____,_____.

SIGNATURE

COPYING OF X-RAYS

If you have supplied your own x-rays at the time of examination <u>or</u> will receive x-rays at our clinic, please note the following policy and sign below:

" I understand that all records/ x-rays supplied by me and/or taken by the Zivkovic Chiropractic Center will become part of my permanent records and remain in the custody of this clinic. I am entitled to obtain copies at any time of my records as long as I sign an authorization for their release and agree to pay the cost of copying those records. I understand that I must give at least 10 (ten) days notice to the Zivkovic Chiropractic Center to allow ample time for copying of my records."

Patient Name :____

Signature :____

Date :____

****

RECEIPT OF NOTICE OF PRIVACY PRACTICES/ WRITTEN ACKNOWLEDGMENT FORM

I acknowledge that I have reviewed a copy of Zivkovic Chiropractic Center's Privacy Practices.
(If you would like a copy to take home please request it at the front desk)

I allow the following individual(s) to be given information regarding care

____

____

Patient/ Legal Guardian Print:____

Patient or Legal Guardian Signature:____

Date:______________________________

EXPLANATION OF CHIROPRACTIC MEDICARE BENEFITS

Medicare does cover chiropractic care, but with limitations. Medicare requires that you have current x-rays of your spine and the x-rays must show a subluxation. Medicare does not cover the cost of the x-rays when ordered or performed by a chiropractor, although Medicare requires them. Also not covered are, any therapy, supports, supplements, examinations or other services offered or done in this office.

The only service covered by Medicare is manual manipulation of the spine. Under some circumstances and with some Medicare carriers, these manipulations are limited to medical necessity this is determined in part by the doctor and Medicare itself per 12 (twelve) month period.

Your condition may require, in our judgement, more treatment than allowed by Medicare and will be your financial responsibility.

Any visits over medically necessary as determined by the doctor and Medicare in this 12 (twelve) month period will be your financial responsibility.

I have read and I understand the above statement.

_____

Signature of Patient Date

_____

Witness

ACCEPTANCE OF LIABILITY

I, _____, Medicare #_____ understand that on _____, I have received the medically necessary manipulations that Medicare allows per 12 (twelve) month period for chiropractic treatment.

I desire further treatments for my condition. I understand the Medicare or the Medicare carrier covering my case may rule these treatments to be “medically unnecessary” in their opinion. I understand that I am financially responsible for these continuing chiropractic visits.

_____

Signature of Patient Date

_____

Witness

A. Notifier: **R.ROBERT ZIVKOVIC, D.C. & ANNETTE CROSKEY ZIVKOVIC, D.C.**

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.** SERVICES 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
99202 EXAMINATION 72040 CERVICAL X-RAY A-P & LAT 72070 THORACIC X-RAY A-P & LAT 72100 LUMBAR X-RAY A-P & LAT	MEDICARE DOES NOT PAY FOR THESE SERVICES WHEN DONE OR ORDERED BY A CHIROPRACTOR	$100.00 $65.00 $70.00 $70.00

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.

Pain Disability Questionnaire

The Pain Disability Questionnaire is used in Chapter 3 Pain (6th ed, 43-44) and Chapter 17 Spine (6th ed, 599-600). The format provided utilizes a centimeter scale to score, however the size in the *Guides* does not correspond with the same scale. An alternative approach (illustrated below) provides easily administered and scored numerical scales.

Patient Name _____ Date _____

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
Work normally — Unable to work at all
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

2. Does your pain interfere with personal care (such as washing, dressing, etc)?
Take care of myself completely — Need help with all my personal care
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

3. Does your pain interfere with your traveling?
Travel anywhere I like — Only travel to see doctors
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

4. Does your pain affect your ability to sit or stand?
No problems — Cannot sit /stand at all
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No problems — Cannot do at all
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems — Cannot do at all
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

7. Does your pain affect your ability to walk or run?
No problems — Cannot walk/run at all
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

8. Has your income declined since your pain began?
No decline — Lost all income
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

9. Do you have to take pain medication every day to control your pain?
No medication needed — On pain medication throughout the day
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

10. Does your pain force your to see doctors much more often than before your pain began?
Never see doctors — See doctors weekly
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
No problem — Never see them
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?
No interference — Total interference
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
Never need help — Need help all the time
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression/tension — Severe depression / tension
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?
No problems — Severe problems
0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10

Anagnostis C, Gatchel RJ, Mayer TG. The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. *Spine* 2004; 29 (20): 2290-2302.