Apex Family Chiropractic and Wellness Center, PA.

Donna Usher King, DC CCSP

1121 Pemberton Hill Road. Apex. NC 27502 PHONE: (919)363-2225 FAX: (919)363-2280

Date ______________________________

How did you find our practice? Health Fair Yellow Pages Website Flyer Other

Patient referral ____ (please give referring patients name)

Patient Name: ____

Address: ____

City _____________________________________ State ______________ Zip code ___________________

Phone Number: (____)_____-______ (Home) (____) _____ - ______ (Work) (____) _____ -______ (Cell)

Social Security # -_______ - _______ _______ Date of Birth: ______ /______/ ______

Marital status: *Single Married Separated Divorced Widowed Other* Gender: *Male Female*

Insurance Information. Same as Above

Insured's Name: ____

Address : ____

City _____________________________________ State ______________ Zip code ___________________

Phone Number: (____)_____-______ (Home) (____) _____ - ______ (Work) (____) _____ -______ (Cell)

Social Security # -_______ - _______ _______ Date of Birth: ______ /______/ ______

Relationship to Insured: Self Spouse Child Other

Insured's Employer Information.

Employer/Company Name: ____

Address: ____

Phone Number: (____)_____-______ (Home) (____) _____ - ______ (Work) (____) _____ -______ (Cell)

If someone other than the insured listed is responsible for payment please provide their information below.

Name: ____ Relationship to Patient: ___________________

Address: ____

City _____________________________________ State ______________ Zip code ___________________

Phone Number: (Home) (Work) (Cell)

Social Security # -_______ - _______ _______ Date of Birth: ______ /______/ ______

Patient Name: ____

Insurance Information (Acknowledgement of Payment Responsibility)

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Apex Family Chiropractic and Wellness Center, PA will prepare any necessary reports and forms to assist me in collecting payment from the insurance company and that any amount authorized to be paid directly to Apex Family Chiropractic and Wellness Center, PA will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend of terminate care and treatment, any fees for professional services already received will become due and payable immediately.

Patient Signature ____ Date ______________________________

Consent to Treatment

I hereby authorize the doctor and whomever they may designate as their assistant to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinical services that they deem necessary for my care.

Patient Signature ____ Date ______________________________

Release of Information

I hereby authorize Apex Family Chiropractic and Wellness Center, PA to disclose or release all or part of my (patient) records to any person or corporation which is liable under contract to the clinic or to the patient or to the family member or employer of the patient for all or part of the clinics charges, including and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patients employer.

Patient Signature ____ Date ______________________________

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Patient Name: ____

Please read the following, check the one that applies to you, and sign below. If you have Health Insurance, please allow us to make a copy so that we may file with your company.

Financial Policy

- ○ **Cash Patient – No Insurance**

  Cash, Personal Checks, Credit cards Payment must be made at the time of treatment.

- ○ **Health Insurance**

  As a courtesy to our patients, we file your health insurance. In addition, we will verify your insurance for chiropractic services. However, please understand that the accuracy of this information is dependent on your insurance company providing accurate information, and is not a guarantee by this office that any services will be paid by without prior warning. Please remember, that while the office does make every effort to obtain payment from your insurance provider, it is your financial responsibility to see that your account is paid. Deductibles and co-pays must be paid at the time of treatment.

- ○ **Workers Compensation**

  As a courtesy, we will file your claim for Worker's Compensation. However, in the event that the bill is not paid by Worker's Compensation, you will be responsible for payment of services rendered.

Medical Supply Fee: Each new patient will be charged a non-refundable disposable medical supply fee, payable at the conclusion of the initial exam. The supply fee covers all medical supplies used in our office, such as electrode pads, Biofreeze, heating and cooling packs, massage oil, sheets and other similar supplies. This fee is not payable by insurance.

Late Cancellation and Missed Massage Appointment Fee: Patients will be charged a $10.00 fee for cancellations made with less than 24 hours notice, and appointments which are not cancelled and not kept.

Collection: Any account that must be sent for collections will have the cost of collections (minimum of 30%), attorney's fees, filing fees and court costs added to the balance due. Also, 1.5% per month will be added to accounts 60 days or more past due.

I have read, understand, and agree to the Financial Policy. I further understand that with or without insurance, I am fully responsible for payment of all services and treatments rendered.

Patient Signature____ Date _____________________

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Patient Name:____

Acknowledgement of Receipt of Notice of Privacy Practices

Apex Family Chiropractic and Wellness Center reserves the right to modify the practices outlines in the notice.

I have read, understand, and received my own copy of the Notice of Privacy Practices for Apex Family Chiropractic and Wellness Center, PA.

Patient Signature____ Date____________________

Patient Representative ___________________________________ Date____________________

(if patient is unable to understand and sign this form for themselves)

Request for Confidential Communication of Protected Health Information

Patient Name____ Date____________________

has authorized confidential communication of protected health information to the following persons.

Designated contact # 1:

Name :____

Address:____

City _______________________________ State __________________ Zip code___________

Phone Number: (____)_____-______(Home) (____) _____ - ______ (Work) (____) _____ -______ (Cell)

Relationship to Patient: Parent Spouse Child Friend Sibling Other

Designated contact # 2:

Name :____

Address:____

City _______________________________ State __________________ Zip code___________

Phone Number: (____)_____-______(Home) (____) _____ - ______ (Work) (____) _____ -______ (Cell)

Relationship to Patient: Parent Spouse Child Friend Sibling Other

Apex Family Chiropractic and Wellness Center, PA.
Donna Usher King, DC CCSP

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Apex Family Chiropractic and Wellness Center, PA does not participate in the selling of your name or information for any reason, nor do we provide information on our patients to telemarketers of any source.

Uses and Disclosures

Treatment:

Your health information may be used by staff members or disclosed to other health care professions for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment:

Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health play may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations:

Your health care information may be used as necessary to support the day-to-day activities and management of Apex Family Chiropractic and Wellness Center, PA; for example, information on the services that you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Law Enforcement:

Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting:

Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state’s public health department.

Other uses and disclosures require your authorization:

A disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

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Additional Uses of Information

Appointment Reminders:
Your health information will be used by our staff to send you appointment reminders.

Information about Treatments:
Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights:
You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Apex Family Chiropractic and Wellness Center, PA Duties.
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices outlines in this notice.

Right to Revise Privacy Practices.
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information:
You may generally inspect or copy the protected health information that we maintain, as permitted by federal regulations. We ask that all requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Dr Donna Usher King. Your request will be reviewed and generally approved unless there are legal or medical reasons to deny the request.

Complaints:
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlines your concerns to the contact person listed below.
If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the contact person listed below.
You will not be penalized or otherwise retaliated against for making a complaint.

Contact Person:
The name and address of the person you can contact for further information concerning our privacy policies and practices is:

Pat Taylor, Practice Manager
Apex Family Chiropractic and Wellness Center, PA
1121 Pemberton Hill Road
Apex, NC, 27502

Patient Health Questionnaire - PHQ

Form PHQ-202

rev 7/18/05

Patient Name ______________________ ***Date*** ______________

1. Describe your symptoms ______________________

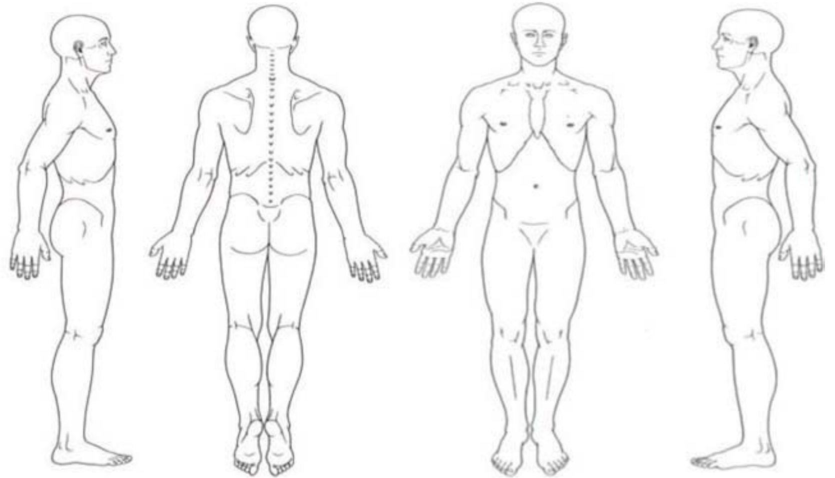
a. When did your symptoms start? ______________________

b. How did your symptoms begin? ______________________

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One ② Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

a. What treatment did you receive and when? ______________________

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* __________ ③ CT Scan *date:* __________
② MRI *date:* __________ ④ Other *date:* __________

9. Have you had similar symptoms in the past?

① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office ② Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

10. What is your occupation?

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time ② Part-time ③ Self-employed ④ Unemployed ⑤ Off work ⑥ Other

Patient Signature ______________________ ***Date*** ______________

Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name ______________________ ***Date*** __________

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ] Feet [ ] Inches Weight [ ] lbs.

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

Past	Present	
○	○	Headaches
○	○	Neck Pain
○	○	Upper Back Pain
○	○	Mid Back Pain
○	○	Low Back Pain
○	○	Shoulder Pain
○	○	Elbow/Upper Arm Pain
○	○	Wrist Pain
○	○	Hand Pain
○	○	Hip/Upper Leg Pain
○	○	Knee/Lower Leg Pain
○	○	Ankle/Foot Pain
○	○	Jaw Pain
○	○	Joint Swelling/Stiffness
○	○	Arthritis
○	○	Rheumatoid Arthritis
○	○	General Fatigue
○	○	Muscular Incoordination
○	○	Visual Disturbances
○	○	Dizziness

Past	Present	
○	○	High Blood Pressure
○	○	Heart Attack
○	○	Chest Pains
○	○	Stroke
○	○	Angina
○	○	Kidney Stones
○	○	Kidney Disorders
○	○	Bladder Infection
○	○	Painful Urination
○	○	Loss of Bladder Control
○	○	Prostate Problems
○	○	Abnormal Weight Gain/Loss
○	○	Loss of Appetite
○	○	Abdominal Pain
○	○	Ulcer
○	○	Hepatitis
○	○	Liver/Gall Bladder Disorder
○	○	Cancer
○	○	Tumor
○	○	Asthma
○	○	Chronic Sinusitis

Past	Present	
○	○	Diabetes
○	○	Excessive Thirst
○	○	Frequent Urination
○	○	Smoking/Use Tobacco Products
○	○	Drug/Alcohol Dependence
○	○	Allergies
○	○	Depression
○	○	Systemic Lupus
○	○	Epilepsy
○	○	Dermatitis/Eczema/Rash
○	○	HIV/AIDS

Females Only

Past	Present	
○	○	Birth Control Pills
○	○	Hormonal Replacement
○	○	Pregnancy
○	○	

Other Health Problems/Issues

Past	Present	
○	○	
○	○	
○	○	

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

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ __________

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

__________ __________ __________

__________ __________ __________

List all the surgical procedures you have had and times you have been hospitalized:

__________ __________ __________

__________ __________ __________

Patient Signature ______________________ ***Date*** __________

Doctor's Additional Comments

____

____

____

Doctors Signature ______________________ ***Date*** __________

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

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.

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 (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

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.

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.

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.

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.

Lifting

⓪ I can lift 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.

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.

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 able to engage in most but not all 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.

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.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

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 very 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 1/2 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 1/2 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 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 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 lift 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.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score