Fogarty
Chiropractic Life Clinic

Kevin Fogarty, D.C., F.I.C.A. (Hon)

Please fill in below:

Name: ____ Date: ____________
Address: ______________________________ Apt: _____ City, State: ____________ Zip: ______
Home Phone: ________________ Work Phone: ________________ Cell Phone: ______________
Gender: M ____ F ____ Date of Birth: ______________ Height: ________ Weight: ______________
Marital Status: ____________ SS#: ______________ Email: ______________________________

Chief Complaint: ____
Mechanism of Injury: ____
____
How long have you had this problem? ____
Are you under the care of any other physician? Yes: _______ No: _______
If yes, please list the doctor (s) you are seeing and the conditions you are being treated for: ______________
____
____
Please list any medication you are presently taking and the reason for taking it: ______________
____
____
Please list any previous surgeries: ____
____
Please list any accidents, auto accidents, or broken bones in the past: _______________
____
Please list previous imaging: ____

Have you been to a chiropractor before? Yes: _______ No: ________ Date of last visit: ______________
How long were you under care? ____________________ Condition treated for: ______________
Name of Chiropractor:
____
Your occupation: ____
Duties you are required to perform regularly at work or home: ________________________
____

Do you smoke cigarettes? Yes: ______ No: ______ # of packs per day: ______________________
Do you drink coffee? Yes: ______ No: _______ # of cups per day: ________________________
Do you consume alcohol? Yes: _____ No: ____ Approximately how much daily? _______________
Do you exercise regularly? Yes: _____ No: ____ What type and how much? ________________

Family Health History

Please describe the health of your:

Father: ______________________________ Mother: ______________________________
Spouse: ________________________________ Children, give ages: __________________

For Official Use:

Blood Pressure: ______/_____ Pulse: _______ Temp: ______

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Females: Is there a possibility of being pregnant? **YES:** ____________ **NO:** __________

Have you **EVER** had any of the following? Please check:

___ Hay Fever	___ Prostate Problems	___ Heart Disease	___ Venereal Disease	___ Ulcers
___ T.B.	___ Gout	___ Thyroid Trouble	___ Hemorrhoids	___ Epilepsy/Seizures
___ Allergies	___ Pneumonia	___ Cancer	___ Tonsillitis	___ Liver Trouble
___ Polio	___ Pleurisy	___ Gall Bladder Trouble	___ Appendicitis	___ Diabetes
___ Slipped Disc	___ Asthma	___ High Blood Pressure	___ Arthritis	___ Rheumatic Fever
___ Stroke	___ Bowel Trouble	___ Menstrual Problems	___ Hypoglycemia	___ Kidney Trouble

Other: ____

Systems Review

Are you **PRESENTLY** suffering from any of the following? Please check:

Eyes:	**Cardiovascular:**	**Musculoskeletal:**	**Cognitive:**	**Skin:**
___ change in vision	___ heart palpitations	___ back pains	___ poor appetite	___ dry skin
___ eye pain	___ chest pains	___ hip pains	___ poor memory	___ skin discoloration
___ watery eyes	**Abdominal:**	___ leg pains	___ insomnia	___itching
Ears:	___ indigestion	___ neck pains	___ inner tension	___ burning
___ ear discharge	___ heart burn	___ shoulder/arm pains	___ nervousness	___ skin eruptions/rash
___ impaired hearing	___ belching	___ other muscle pains	___ personality change	___ excessive sweating
___ ear aches	___ vomiting	___ numbness	**Pulmonary:**	___ bruising
___ ringing in ears	___ rectal bleeding	___ tingling	___ cough	**Other:** (Please list)
Nose:	___ irritable bowel	___ joint pains	___ shortness of breath	____________
___ sinus pains	___ gas	___ swelling of ankles	___ dizziness	____________
___ nose bleeds	___ constipation	___ swelling of joints	___ fainting	____________
Throat:	___ diarrhea	**Neurological:**	**Urinary:**	____________
___ blisters in mouth	___ abdominal pains	___headaches	___ blood in urine	____________
___ problems swallowing	___ nausea	___ balance issues	___ frequency of urination	____________
___ throat lumps	___ change in weight	___ fatigue	___ pain on voiding	____________
___ sore throat	___ swelling	___ weakness	___ cloudy urine	____________

Insurance information:

Type of insurance: Regular Medical ____ Medicare ____ Medicaid ____ Auto _____ Workers Comp _____

Name of Insured: ______________________________ SS # ______________________________

Insured's Date of Birth: ____________________ Name of Employer: ______________________________

Insurance Company: ______________________________ Phone #: ____________________

Policy #: ____________________ Group # ______________ Claim #: ____________________

Emergency Contact:

Name: ______________________ Phone # ____________

Relationship to patient: ______________________________

I certify to the best of my knowledge, the above information is complete and accurate. I agree to notify this practitioner immediately whenever I have changes in my health condition.

Patient Name: ______________________________ Date: ______________________

Signature: ______________________________ Relation to patient: ______________________

(Revised 07/13/23)

Fogarty

Chiropractic Life Clinic

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Financial Responsibility

Lifet me Assignment and Instruction for Direct Payment to Doctor
Private and Group Accident and Health Insurance
Authorization to Release/Request Records

Patient Name: ______________________________ Date of Birth: ____________________

I hereby instruct and direct my Insurance Company of record to pay benefits by check or electronic payment.

Fogarty Chiropractic Life Clinic
839 Barton Blvd.
Rockledge, Florida 32955

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional service rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY TO FOGARTY CHIROPRACTIC LIFE CLINIC FOR PAYMENT OF PROFESSIONAL SERVICES RENDERED**. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I assign to said clinic all rights patient has under any contract of insurance for collection of same.

This also certifies that the above-named individual agrees to pay in full for all professional services rendered at the time they are preformed, unless other arrangements are made in advance of the set appointment. The below named guarantor understands a $50.00 returned check fee will be charged along with any appropriate collection or attorney's fee which may accrue upon collection of any outstanding balance.

____
Initials

RECORDS REQUEST

This is to certify that the above-named patient authorized full request of any records pertinent to the health care of same individual from but not inclusive and any insurance carrier, adjustor, attorney, hospital, or other health care provider.

This also authorizes Fogarty Chiropractic Life Clinic to release records, upon receipts of the above-named patient's signature, or on an emergency basis, to but not inclusive of any insurance carrier, attorney, health care provider, hospital, or immediate family member.

____
Initials

A photocopy of this assignment shall be considered as effective and valid as the original. This document is considered a living document and does not expire.

HIPAA

Privacy: The *Standards for Privacy of Individually Identifiable Health Information* ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human services issued the Privacy Rule to implement the requirement of the *Health Insurance Portability and Accountability Act of 1996* ("HIPAA"). A major goal of the Privacy Rule to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and wellbeing.
You can be assured that our clinic takes your privacy seriously and is in compliance with all HIPAA guidelines. Your health information will not be disclosed without permission or will your name, address, or telephone numbers be disclosed to any third party.

I received a copy of the HIPAA Policy _______
Initials

CONFIDENTIAL COMMUNICATIONS

Use this section to **AUTHORIZE** others who may contact Fogarty Chiropractic Life Clinic to obtain PHI and to communicate with our practice regarding the patient above. For example: Spouse, children, parent, friends, etc.

Authorized User #1: ______________________________ Date of Birth: ____/____/______
Relationship to you: ______________________________ Phone#: ______-______-______

Authorized User #2: ______________________________ Date of Birth: ____/____/______
Relationship to you: ______________________________ Phone#: ______-______-______

Select one of the following options

______ **I AUTHORIZE** Fogarty Chiropractic Life Clinic to leave detailed messages on my answering device.

______ **I DO NOT AUTHORIZE** Fogarty Chiropractic Life Clinic to leave detailed messages on my answering device.

NO SURPRISES PAYMENT OPTIONS

Fogarty Chiropractic Life Clinic knows how important your health and wellness care are. And it is our top priority to ensure that each patient gets the care they need. We want to make sure that and your family get the best quality of care regardless of insurance high deductible plans, copays, and non-covered services so there are "no surprises".

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost. Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescriptions drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400.00 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.

Due to the increased frequency of high deductible insurance plans and out of network policies we offer a discount care program we refer to as our HMA Plan
(Healthcare Made Affordable). This allows us to legally treat our patients at a discounted rate regardless of insurance provider. Ask for more information on your first visit. I received a copy of the Fee Explanation sheet & No Surprise Act. ______
Initials

I have read and understand all the foregoing. I have also received a copy of the HIPAA privacy statement and Fogarty Chiropractic Life Clinic's Fee Sheet.

Date: ____________________ Patient Signature: ______________________________

(Revised 02/3/2023)

Kevin Fogarty, D.C., F.I.C.A. (Hon)

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we prescribed, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable. Please feel free to communicate any discomfort or concern with the doctor.

We may need to conduct diagnostic procedures such as spinal radiographic imaging or to recommend MRI's if indicated. It is important that you inform us if there is any possibility of pregnancy.
Chiropractic care centrally involves what is known as the chiropractic adjustment. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joints, and improving neurological functioning and overall well-being.

Treatment recommendations may include the use of modalities including but not limited to: intersegmental traction, cold laser therapy, massage therapy, trigger point therapy or ice as part of your care

Decompression therapy. Spinal decompression is a non-invasive and non-surgical therapy which addresses the intervertebral discs. I understand that spinal decompression treatment is designed to alleviate certain symptoms through a conservative approach with hopes to avoid a more invasive procedure.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the- counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as

is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: ______________________________ Signature: ______________________ Date: ______

Parent or Guardian: __________________________ Signature: ______________________ Date: ______

Witness Name: ______________________________ Signature: ______________________ Date: ______

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MEDICARE EXPLANATION SHEET

In order to better understand how Medicare works, our clinic has prepared this explanation for you. Please read it over carefully, as it will probably save you some misunderstanding. If you still have any questions after reading this sheet, please feel free to ask one of our staff.

MEDICARE PAPERWORK:

1. On your first visit, one of our staff will ask to see your Medicare card. This gives us the basic information we need to process your Medicare.
2. You will be asked to sign an "Assignment of Benefits" sheet from our clinic. This gives us permission to bill Medicare directly for payment. Without this you would be required to pay the entire bill in full at the time services are rendered.
3. You will be required to fill out a neck and back Bournemouth Questionnaire on your initial visit and every 30 days after that.
4. Each calendar year, from January 1st to December 31st, Medicare requires that you meet a deductible with any health care provider. If you have submitted any doctor bills this year, we will need you to bring in the return statement that Medicare has sent to you in the mail. This is called an "explanation of Benefits." This sheet is the only way we have of verifying that you have met your Medicare deductible for this year. If, of course, your deductible has not been met when you start care with us, you will have to meet it with our clinic.

WHEN YOU START CHIROPRACTIC CARE:

When you first start care in our clinic you will need to have both a spinal examination and spinal x-rays to determine the exact nature of your problem. This is an integral part of your care here in our clinic. Even though both this clinic and Medicare require these services, Medicare unfortunately will not pay for these services, nor will they apply them towards the deductible. Thus, both the examination and the x-rays remain your responsibility. This is why Medicare requires you to sign an ABN form on your initial visit. If you are a returning patient to this clinic or someone who wishes to submit qualified visits to Medicare, Medicare requires an examination be performed on a yearly basis and x-rays be performed every 3 years to determine the presence of a subluxation to necessitate care.

THE ADJUSTMENTS:

The only service Medicare will pay for in a chiropractor's office is the adjustment visit. Medicare will only pay for visits that are considered "acute" in nature and will not pay for visits that they consider "chronic/maintenance". Your Medicare carrier interprets acute as an "exacerbation (aggravation of a chronic condition or a new injury documented by examination and or x-rays". Our clinic will only file adjustment visits which will be reimbursed by Medicare for acute phase of care. It does not mean that you health does not require additional coverage. It means that Medicare will not pay for care that they consider maintenance and will only pay for enough care to get your started. Please pay attention to your Medicare Explanation of Benefits and make us aware of any changes or conflicts.

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Medicare denying payment for a service does not mean the service is not medically necessary; it means that it does not qualify for "acute care" reimbursement. It is still your responsibility to provide payment for service provided. We always have to documentation of "medical necessity" for the services you receive, in the event you wish to dispute a denial with the Federal Government and the Medicare Bureaucrats.

HOW MEDICARE CONSIDERS ADJUSTMENT VISITS:

1. Our normal adjustment visits range from $60.00 to $75.00, depending on the type of adjustment you receive.
2. We are under contract with Medicare for a reduced fee, which Medicare determines each calendar year. This year it is $39.20 per visit.
3. Medicare pays 80% of the Medicare set amount and you are responsible for 20% of this same amount, once your deductible is met for the year.
4. If you have not met your calendar year deductible, you must meet it at the full fee set by Medicare until you have reached the $240.00 total deductible.
5. By law we must submit a charge to Medicare for our normal fees. You will see this fee on your Explanation of Benefits that Medicare will send you with their deductions indicated.

**NOTE:

Our clinic will only file your secondary insurance if it is an approved Medigap participant. These insurance companies can be found in the Medigap listing booklet. If they are not listed, we cannot file for you, leaving this responsibility up to you.

We hope this information will help avoid any confusion so that your care here will be both helpful and healthful. Our clinic will do its utmost to keep you informed of Medicare's ever-changing policies. I you feel the Medicare system is unjust, please write to your Congress person and air your views to them, as they are the ones who can change Medicare's policies with your feedback.

I have read the above information and understand that there may be some services rendered in this office which Medicare may not pay for. I understand I will be responsible for any services Medicare does not pay for, and I authorize the doctor to provide care for me. I further state that the only services that I request to be sent to Medicare are those which are acute in nature.

____

Signature

________________________________ __________________

Print Name Date

Revised 01/01/2024

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name ______________________________ Date ____________________

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week on average, how would you rate your back pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

____
Examiner

OTHER COMMENTS: ____

With Permission from: Bolton JE Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name ______________________________ Date ____________________

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

____
Examiner

OTHER COMMENTS: ______________________________

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.