HARCHAK CHIROPRACTIC CLINIC, LLC
1114 Walton Street
Philipsburg, PA 16866

PATIENT INFORMATION

PATIENT NAME:

Last Name _____ First _____ Middle _____

Gender: Male○ Female○ Date of Birth ____ / ____ / ____ Age _____

SS# _____

Home Address_____

City _____ State_ _____

Zip_____

Home Phone _____ Cell Phone _ _____

Personal Email:_____

Employer Name _____ Phone_____

Employer Address _____

City _____ State_ ____ Zip_____

SPOUSE *or* GUARDIAN:

Last Name _____ First _____ Middle _____

Employer Name _____ Phone _____

_____

Date of Birth ____/____/____ SS# _____

EMERGENCY: *Name and address of nearest relative or friend not living with you.*

Last Name _____ First _____ Middle _____

Home Phone _____ Cell Phone _____ Work

Phone_____

Relation to Patient

_____

PAYMENT METHOD: For all services that are not paid by a third party (Insurance, Medicare, Medicaid).

Cash ○ Check ○ Visa ○ Mastercard ○ Discover ○ American Express ○

If you have any insurance coverage that might pay a portion of your financial obligations, please ask about our policy.

MY CERTIFICATION

I certify that the above information is correct and I request services.

x _____

Signature of patient or person acting on patient's behalf *Date*

HARCHAK CHIROPRACTIC CLINIC LLC

MEDICAL *and* HEALTH HISTORY

Date _____ Patient Name _____ Date of Birth_____

MAIN PROBLEM

What pain causes you to come to the office? _____

What caused this pain?_____

When did this pain start?_____

How long does this pain usually last?_____

How bad is this pain? (Circle one - 1= mild pain - 10= intense pain) 1 2 3 4 5 6 7 8 9 10

Circle the word or words that best describe the pain:

Cramping ☐ Aching ☐ Dull ☐ Sharp ☐ Shooting ☐ Bright ☐ Diffuse ☐

Lightening-like ☐ Throbbing ☐ Nagging ☐ Burning ☐ Deep ☐ Stinging ☐ Pressure-like ☐

How often does the pain occur? (Circle one) Occasional Frequent Constant

Does this pain travel to any other area?_____

What makes this pain better?_____

What makes this pain worse?_____

Are there other symptoms that occur with the pain? Stiffness, weakness, cramping-muscle spasms, swelling, other _____

What else have you done to treat this pain? Ice packs ☐ Heating pads ☐ Hot showers ☐ Rest ☐ Over the Counter pain meds. ☐ Other:_____

OTHER PROBLEM

Do you have another problem or other pain? _____

What caused this pain/problem?_____

When did this pain/problems start?_____

How long does this pain last?_____

How bad is this pain? (Select one - 1= mild pain - 10= intense pain) 1 2 3 4 5 6 7 8 9 10

Select the word or words that best describe the pain:

Cramping ☐ Aching ☐ Dull ☐ Sharp ☐ Shooting ☐ Bright ☐ Diffuse ☐

Lightening-like ☐ Throbbing ☐ Nagging ☐ Burning Deep ☐ Stinging ☐ Pressure-like ☐

How often does the pain/problem occur? (Select one) Occasional ☐ Frequent ☐ Constant ☐

Does this pain travel to any other area?_____

What makes this pain better? _____

What makes this pain worse? _____

What else have you done to treat this pain? Ice packs Heating pads Hot showers Rest Over the Counter pain meds. Other: _____

Are there other problems you would like to discuss today? _____

_____

OTHER HISTORY

Do you smoke? Yes ◯ No ◯ If yes, how many per day? _____

Do you drink? Yes ◯ No ◯ If yes, how much? _____

Do you exercise regularly? Yes ◯ No ◯ If yes, how often? _____

Are you pregnant? Yes ◯ No ◯ Date of last physical exam _____

Are you employed ? Yes ◯ No ◯ Where _____

How would you rate your daily amount of stress? (*select one*) Low/None ☐ Moderate ☐ High ☐ Extremely High ☐

Do you have children? No ◯ Yes ◯ If yes how many? _____ Youngest age is: _____ # at home _____

Are you married? Yes ◯ No ◯ Status: Never ☐ Separated ☐ Divorced ☐ Spouse ☐ Deceased ☐

How is your overall health? _____

List past illnesses _____

_____

Does your family have serious medical problems that appear to be inherited, i.e. "that run in your family?"

No ◯ Yes ◯ *describe:* _____

Surgeries / Hospitalizations / Injuries _____

_____

Medications - Purpose

_____

_____

(*Use other side if necessary*)

PRIVACY PROTECTION:

I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: plan, coordinate and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third party payors; Conduct normal healthcare operations such as quality assessments and accreditation.

x _____ Date _____

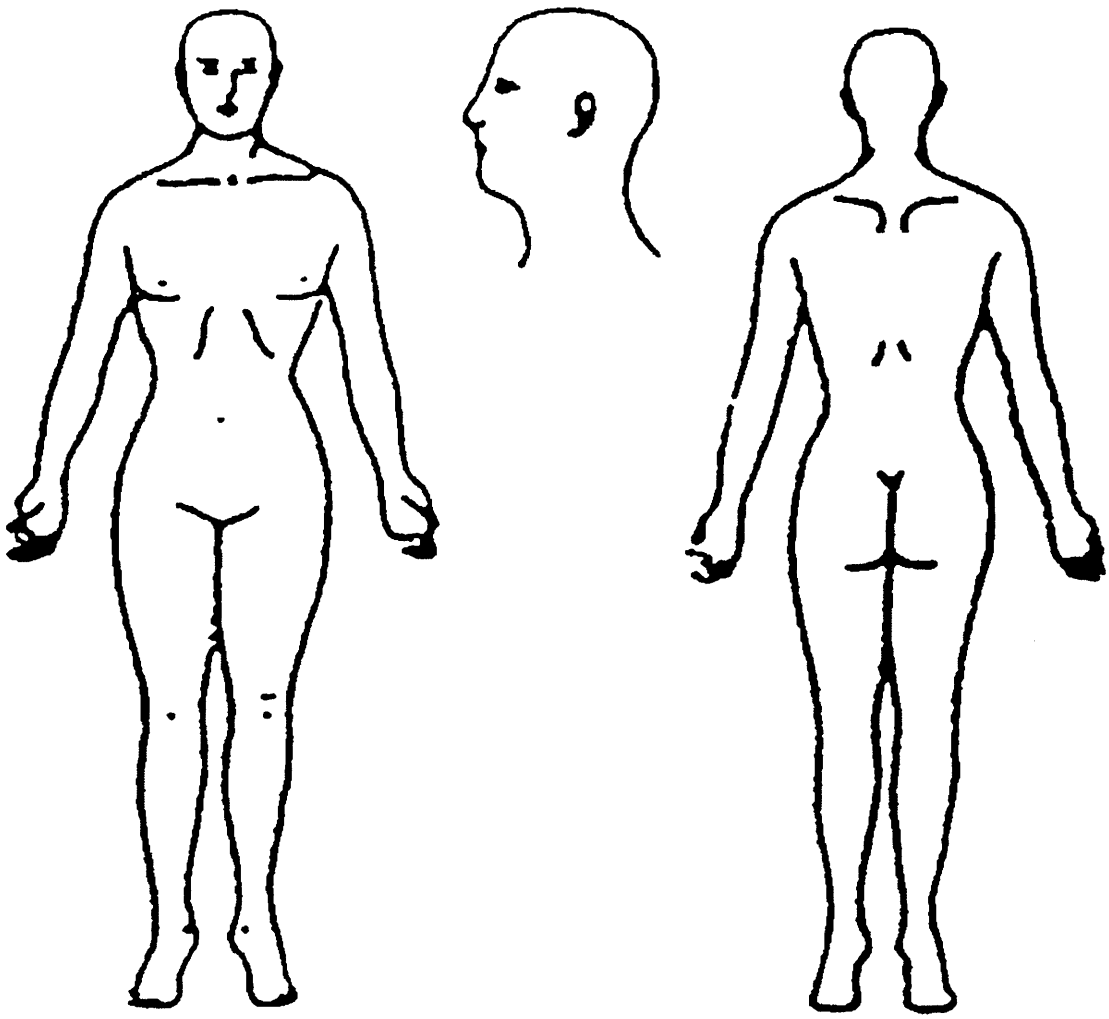
Signature of patient or person acting on patient's behalf

SYMPTOM DIAGRAM

Name _____ Number _____ Date _____

Please be sure to fill this form out extremely accurately. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.

Aches ΛΛΛΛ Numbness oooo Pins/Needles ●●●● Burning xxxx Stabbing ////



Reference: Randsford. Spine, Vol. 1, No 2, June 1976

Patient's Name_____ Number_____ Date_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

- ☐ I can tolerate the pain without having to use painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

Section 2 -- Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than one-half mile.
- ☐ Pain prevents me from walking more than one-quarter mile
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 9 – Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain is bad but I manage journeys less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at the present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

Harchak Chiropractic Clinic LLC

Financial Disclaimer

Dear Patient,

Welcome to Harchak Chiropractic Clinic! We are pleased that you have chosen our clinic to address your healthcare needs. We would like to take a few minutes to explain what you can expect from your insurance company as well as what we in turn expect from you.

Your benefit under your insurance plan for chiropractic care may change from year to year and may have limited coverage. You are financially responsible for co-payments, co-insurance and deductibles for covered services. Services exceeding benefit limits or considered maintenance or preventative are not reimbursable by your plan. You are also financially responsible for all non-covered services. Please feel free to discuss any questions with our accounts department.

If your doctor feels that some of your care will not be a covered expense based on the type of care you are receiving, it may be in your best interest to discuss one of the several self- pay financial plans.

• If at any time there is a change in your insurance benefits it is **YOUR RESPONSIBILITY TO NOTIFY OUR BILLING DEPT. WE CAN NOT BE RESPONSIBLE FOR BACK BILLING IN THESE SITUATIONS.**

• Please understand that any benefit quoted to you by this office is **NOT A GUARANTEE** that your insurance co. will make payment on your claims.

• **YOUR CO-PAY, CO-INSURANCE, AND OR DEDUCTIBLE IS DUE AT THE TIME OF YOUR VISIT.** We also welcome payments in advance by **cash, check, Visa, MasterCard, American Express, and debit cards.**

Also note: If you are filing your claims through AUTO INSURANCE or WORKMAN'S COMPENSATION, the insurance may not settle in your favor or your case may be denied, at which point you will be responsible to pay your balance.

By signing this statement, you acknowledge you understand the services you are receiving may not be covered by your health plan, and in that situation, you would be 100% responsible for all charges incurred.

_____ _____

Signature Date

Harchak Chiropractic Clinic LLC

Non-Covered Services: Financial Disclosure Form

Chiropractic services typically covered by health insurance policies include:

- Chiropractic adjustment for acute clinical conditions
- Limited treatment of symptom flare-ups or exacerbations.

Services that we expect to **NOT** be eligible for reimbursement through your plan's chiropractic benefit and therefore will likely be your financial responsibility are outlined below. Your financial responsibility is limited to services received during the treatment dates below.

Treatment plans start date: 01/01/2025 Treatment plan end date: 12/31/2025

Non-covered Services and Cost per Visit*

• New Patient Exam(s)	$65
• NUTRITIONAL SUPPLEMENTS	Depends on Product
• Maintenance Care Spinal Adjustments	$43
• X-Ray(s) to detect subluxation	$80
• Stim, Ultrasound Therapy	$15
• Decompression Therapy	$55

I acknowledge that I am signing this statement voluntarily, and that it is not being signed after the services have already been provided. I have had ample opportunity to ask questions about my liability and the provider/staff has answered them to my satisfaction. I understand that I have the right to refuse this care and that by signing this form, I will be fully responsible for the total billed charge(s) related to non-covered services.

Patients Signature : _____ Date : _____

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Patient Copy

Maintenance Care Disclaimer Form

This brief handout defines the two phases of chiropractic care and explains which is covered through your health insurance. The "Maintenance" care phase is NOT covered through your health insurance. Any financial responsibility you may have for choosing to receive care in your maintenance phase will be reviewed with you by your chiropractor prior to receiving care.

When is chiropractic care covered by my health insurance? Chiropractic care is covered by your health insurance plan if it is for **acute (short-term) care such as a recent injury.**

Is there a certain amount of treatment that is covered? For most plans, the amount or length of treatment that is covered by insurance can sometimes be defined by the number of visits or types of treatment. Treatment is historically covered as long as it demonstrates significant, lasting, or progressive improvement to your condition.

When is chiropractic care NOT covered by my insurance plan? Chiropractic care is NOT covered by your health insurance plan when you reach a certain point in treatment where chronic symptoms remain stable or where you no longer show progress in reducing these chronic symptoms through chiropractic care. At this point, you have reached what is called **"maintenance" care**. Because this "Maintenance" care phase is NOT covered through your health insurance. Any financial responsibility you may have for choosing to receive care in your maintenance phase will be reviewed with you by your chiropractor prior to receiving care.

How will I know if I have reached the end of covered care? Your chiropractic provider will let you know when you have reached the point of "maintenance" care and will discuss further care options.

What happens when I am determined to have reached the end of covered treatment, but I still want to have regular chiropractic adjustments? You may continue maintenance treatment, but you must self-pay for this service. If you choose to receive chiropractic care beyond acute care, it is a self-pay service where you would be responsible for payment.

How will I know what maintenance care will cost me? Prior to receiving maintenance care, your provider will have you sign a Financial Disclosure Form, letting you know in advance the cost of the elected services.

Is it possible to move from maintenance care back to chiropractic care covered by my insurance plan? If you sustain a future incident or injury, your chiropractic care would meet the criteria for acute care and would be covered by your health plan, until that condition has reached a plateau level and does not provide any more lasting, curative value.

Who should I contact with questions? Please contact your health plan's customer service department for any specific questions regarding your benefit coverage.

I understand that I have the right to refuse this care and that by signing this form, I will be fully responsible for the total. HAVE PATIENT SIGN AND DATE THIS FORM YEARLY.

Patient's Name: _____

Patient's Signature: _____ Date: _____

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Patient Copy

MISSED APPOINTMENT POLICY

Out of respect and consideration for our practice members, we kindly ask you to honor your scheduled appointment time. Please note that appointment space is limited daily, and both of our doctors have a waiting list.

We understand unanticipated events occasionally occur. In our desire to be effective and fair to all of our clients' time, we ask you to give a minimum of **24-hour** advance notice when cancelling an appointment. This allows the opportunity for someone else to schedule and utilize your valuable appointment space.

We are happy to excuse **ONE** missed appointment with no penalty. If there is a **SECOND** missed appointment, you will be charged a **$25** cancellation fee which is applied to your account. Insurance will not be billed for these charges. Cancellation fees are the responsibility of the patient and must be paid in full before the next visit.

When utilizing our text messaging appointment reminder system to confirm your appointments, if you choose to cancel, that cancellation must be done within **8 hours** of your scheduled appointment time, or it will be considered a late cancellation and subject to the cancellation fee of **$25**. This allows the opportunity for someone on our waiting list to schedule and utilize your valuable appointment space.

I have read and understand the Harchak Chiropractic Clinic Appointment Cancellation Policy. I am aware that I will be charged for the missed appointment, and I agree to these terms.

I, _____, have received a copy of the Cancellation policy.

_____ _____

Signature of Patient Date

MISSED APPOINTMENT POLICY

Out of respect and consideration for our practice members, we kindly ask you to honor your scheduled appointment time. Please note that appointment space is limited daily, and both of our doctors have a waiting list.

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Patient copy

ACKNOWLEDGEMENT OF RECIEPT OF THE NOTICE OF PRIVACY PRACTICES OF HARCHAK CHIROPRACTIC CLINIC LLC

Herein after referred to as *the clinic*

I acknowledge that I was provided a copy of the Notice of Privacy practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that these privacy practices will be followed by *the clinic* to ensure the privacy of my personal health information. I understand that this form will be placed in my patient chart and maintained for six years.

_____ Date _____

Patient Name (please print)

_____ Date _____

Signature of Patient, Parent, Legal Guardian or Patient's Legal Representative:

Please list below the names and your relationship of people to whom you authorize *the clinic* to release your private health information.

Name: _____ Relationship _____

Name: _____ Relationship _____

Name _____ Relationship _____

* This form will be placed in the patient's chart and maintained for 6 years

Harchak Chiropractic Clinic LLC

Susan I. Harchak DC
Aaron R. Harchak, DC
1114 Walton Street
Philipsburg, PA 16866

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be use to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: The state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(signature) (date)

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle. _____

_____ _____
(signature) (date)