Javersak Chiropractic & Spine Center

Dr. Shayne Javersak, *Chiropractic Physician*

1501 E Wade Watts Ave. McAlester, OK 74501

Telephone: (918) 423-1873 Fax: (877) 310-9896

↓**Office Use Only**↓

Cash / INS / PI / WC
Company:

↓**Office Use Only**↓

Case No.
Date:

General Information

First Name: _____

Middle Initial: _____

Last Name: _____

Suffix: _____

"Called Name" _____

Mailing Address: _____

City,State,Zip: _____

Physical Address: (IF DIFFERENT FROM MAILING)

_____

Home Phone ONLY: _____

Work Phone: _____

Cell Phone: (Text Notifications) _____

Other: (ex. Spouse/parent) _____

Email Address: _____

_____

Sex: (Circle) Male Female

Marital Status: (Circle) Single Married Divorced Other _____

Birthdate: _____

Social Security: _____

Who Referred You? _____

Phone(to thank them) _____

Insured' s Information

FILL OUT BELOW IF YOU ARE **NOT** THE INSURED!

Relationship to insured:(Circle) Same/Self Husband Wife Child Other

First Name: _____

Last Name: _____

Address (if different than above): _____

City, State, Zip: _____

Phone Number: _____

Date of Birth: _____

In Case of An Emergency

Emergency Contact _____

Emergency Phone _____

Relationship to You _____

Primary Physician _____

Phone Number _____

Primary Physician Location _____

Credit/Debit Card On File Policy:

Effective January 2018

- We have implemented a policy which conveniently stores your credit/debit card information confidentially & securely on file after 1st card use. This policy relates to all payments not covered by the insurance company for services rendered. This also includes any no show fees, copays, outstanding balances, and/or products.
- **We will continue to send statements by mail, especially if your insurance denies any services, however if the credit card is on file, then we will charge the card then send the statement.**
- Any balances prior to the effective date: We will not charge more than $300 at one time, unless authorized.
- If you have a discrepancy with the charges, you must first contact your insurance company regarding their determination of payment.
- If you do not wish to store your card securely in our software, then you must pay by CASH or CHECK.
- To cancel, you must give a **60 day notification, in writing**, and the **account must be in good standing.** You must then start paying with cash or check from that day forward.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered; I certify that, to the best of my knowledge, I have completed this form with the complete and accurate information. If this information changes I will notify this office in a timely manner.

Patient (Guardian) Signature:

_____

Date: _____

Javersak Chiropractic & Spine Center
OFFICE POLICIES & PROCEDURES AGREEMENT

It is the intention of all personnel in this office to provide for your chiropractic needs as thoroughly and efficiently as possible. Therefore, we wish to acquaint you with our policies.

Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy.

USUAL & CUSTOMARY RATES:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of the insurance company's arbitrary determination of usual and customary rates. As a courtesy to our patients, we do send out medical claims to the insurance carrier. In case of late billing, the Oklahoma statute of limitations for a medical debt is five years from the date of service.

INSURANCE (Major Medical):

1. Your health insurance policy is an arrangement between you and your health insurance carrier. We are not a party to that contract. **It is the patients' responsibility to know if their insurance covers chiropractic care, or if they need to have pre-approved visits.** Our office is a participating provider with a number of insurance companies. As a courtesy to our patients, our office does file insurance claims on the behalf of our patients, **but there is no guarantee benefits even if approved/authorized, in addition, verification of benefits is not a guarantee of payment.**
2. **Patients are ultimately fully responsible for products purchased and services provided by our office that are not authorized or covered by their insurance company. If your insurance policy has a deductible or co-payment amount, it must be paid at the time of service.**
3. Please understand that if you receive a bill in the mail, it is because the insurance company stated that you owe more than we collected at the time of service. Should there be problems with an insurance claim, first direct your question to your insurance carrier. Our office will be pleased to help you if they can be of any assistance in resolving a problem.

PATIENTS WITHOUT INSURANCE: A small discount is provided for patients who choose to pay in full at the time of service that do not have insurance. Please note if a patient has insurance, but chooses not to file a claim, our office WILL NOT file ANY services to the insurance company NO EXCEPTIONS! We require services be paid in full for the first visit at the time of service, and full payment at every visit thereafter. We are happy to accept personal checks, cash, MasterCard, Visa, Discover, or CareCredit.

MEDICARE: We do accept assignment from Medicare and we will bill secondary insurance claims if needed. Coverage of chiropractic services is specifically limited to manual manipulation of the spine only. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20% as well as any non-covered services. Medicare DOES NOT PAY FOR EXAMS, X-RAYS, THERAPIES, NUTRITIONAL SUPPLEMENTS, OR ANY OTHER SERVICES RELATED TO CHIROPRACTIC CARE. All new patients to our office will receive an Initial Examination in order to determine what treatment is necessary.

"ON THE JOB" INJURY (Worker's Compensation):

If you are injured on the job, YOU MUST HAVE A REFERRAL FROM YOUR MEDICAL DOCTOR.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS:

Please present all auto insurance forms and/or police reports at time of initial visit. If an attorney is handling your case, please notify our office immediately with all attorney information. Although you are ultimately responsible for your bill, our office will wait for settlement as long as you are an active patient or the case is open. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

1. Comprehensive Medical Payment (Med Pay) - The injured patient or owner of the auto has Med Pay as required by insurance law. This is a benefit of your insurance policy. Your med pay coverage is the primary source of treatment coverage in the event of an accident. Your car insurance company covers your treatment now and they get reimbursed from the insurance company of the person who is at fault.

MISSED APPOINTMENT POLICY: We reserve the right to charge a $20 fee for appointments that are missed or appointments that are cancelled without notice of at least twenty four (24) hours. The $20 fee is your bill, not your insurance company's bill.

Billing: STATEMENTS & INTEREST: Account statements are sent according to the office staff's discretion. Please note that our office can send out billing statements for up to 4 years from each date of service (starting January 1st of every year). We reserve the right to add interest charges, plus any late and legal fees. The clinic can't guarantee and are not liable for any wrong information given by your insurance company. The patient is responsible for all collection fees to include an interest rate on all the unpaid balances, attorney and collection agency fees.

1. Accounts greater than 60 days: If account is not paid in full within 60 days (upon invoice date) and no financial arrangements have been made(within 30 days),you will be responsible for legal fees, collection agency fees, interest charges, and any other expenses incurred in collecting your account.

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- If you have a discrepancy with the charges, you must first contact your insurance company regarding their determination of payment.
- If you do not wish to store your card securely in our software, then you must pay by CASH or CHECK.
- To cancel, you must give a **60 day notification, in writing**, and the **account must be in good standing.** You must then start paying with cash or check from that day forward.

INFORMED CONSENT TO CHIROPRACTIC CARE

I request and consent to the performance of any and all other chiropractic procedures permitted by our State law. Chiropractic adjustment, therapeutics modalities (ultrasound, heat, electrotherapy, decompression, traction and manual muscle therapy), and acupuncture are considered safe and effective methods of care. While chances of complications are small, it is the practice of this clinic to inform our patients about them. These complications include but are not limited to: soreness, inflammation, soft tissue injury, dizziness, and worsening of symptoms.

If you have a condition that would otherwise not come to Dr. Javersak's attention it is **your responsibility** to inform him.

I understand that results of treatment are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications of my case, and I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based on the facts then known, and is in my best interest. This consent form covers the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I have read and understand all policies provided by Javersak Chiropractic & Spine Center.
I understand & agree that health and accident insurance policies are an arrangement between an insurance carrier and myself, NOT between Javersak Chiropractic & Spine Center and my insurance carrier. I also understand if I suspend or terminate my schedule of care as prescribed by Dr. Shayne Javersak that fees will be due and payable immediately. I also acknowledge that I as the patient or legal guardian of the patient, I am ultimately and personally responsible for any and all costs associated with the course of my treatment and care at Javersak Chiropractic & Spine Center (this includes deductible, co-pays, and/or any coinsurance amounts).

In accordance with all stated above, I hereby understand and agree to the above stated office policies.

Signature:

_____
(Patient, Parent or Legal Guardian)

Date:

_____/_____/_____

Name____ Date______________________

Present Complaints

SEPARATELY list all symptoms you are experiencing today **SEPARATELY** Choose the severity level associated with each symptom

____________________________________ ☐(1)Very Mild ☐(2) ☐(3) ☐(4) ☐(5) ☐(6) ☐(7) ☐(8) ☐(9) ☐(10)Remarkably Severe

Frequency of Pain= ☐Constant (76%-100%) ☐Frequent (51%-75%) ☐Intermittent (26%-50%) ☐Occasional (25% or less)

Type of Pain= ☐Aching ☐Burning ☐Dull ☐Pulling ☐Sharp ☐Shooting ☐Stabbing ☐Stinging ☐Throbbing
☐Stiff ☐Sore ☐Numbness ☐Tingling ☐Weak ☐Swelling ☐Cramp ☐Muscle Spasms ☐Restricted Motion

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1. Since your problem(s) began is the pain: ☐Increasing ☐ Decreasing ☐Not Changing

2. When did your problem(s) begin? Date(s):____

3. Did your problem(s) begin: ☐Immediately after a specific incident ☐Multiple incidents ☐Gradually over time ☐No specific reason

4. Describe how your problem(s) began:____

____

5. What treatment have you received for this condition in the past? ☐None ☐Surgery ☐Spinal Injections ☐PT Therapy
☐Back Support ☐Medications______________________________ ☐Other______________________________

6. Were you previously treated for a different occurrence of this same condition? ☐Yes ☐No (if yes by): ☐Chiropractor ☐MD/DO
☐Therapy ☐Other______________________ (dates&type of treatment w/results)______________________________

7. What makes your problem better? ☐Nothing ☐Lying down ☐Walking ☐Standing ☐Sitting ☐Sitting ☐Movement ☐Inactivity

8. What makes your problem worse? ☐Nothing ☐Lying down ☐Walking ☐Standing ☐Sitting ☐Sitting ☐Movement ☐Inactivity

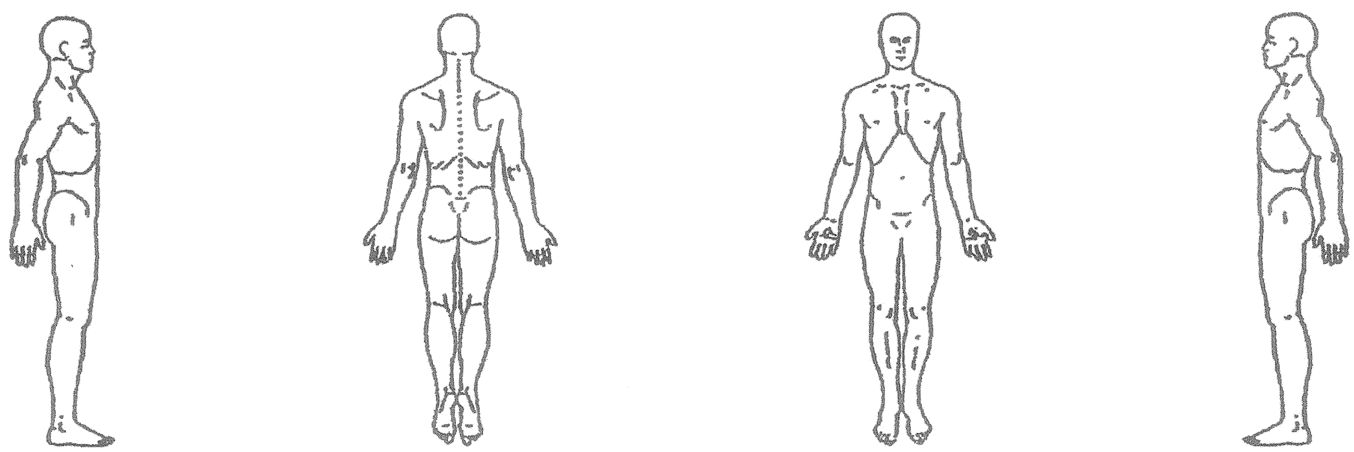
9. How would you grade your general stress level? ☐No stress ☐ Minimal stress ☐Moderate stress ☐Greatly stressed

10. Physical Activity at work: ☐Sitting more than 50% ☐Light manual labor ☐Manual labor ☐Heavy manual labor

11. General physical activity: ☐No regular exercise program ☐Light exercise ☐Strenuous exercise

12. Are your complaints affecting your ability to work or otherwise be active? ☐No effect ☐Some physical restrictions(able to perform light duty & household tasks) ☐Need limited assistance with everyday tasks ☐Need assistance often ☐Have a significant inability to function without assistance ☐Totally disabled (impaired,cannot care for yourself)

Mark an X on the picture where you have pain



Mark an X on the picture where you have pain

Case History

Date_____ Case Number_____

Patient_____ DOB ___/___/___ Age_____

Sex____M____F Number of Children_____ Chief Complaint?_____

Past Chiropractic Care? _____ Dr.'s Name _____ Results _____

Please check the one's you have experienced in the last 3 months.

GENERAL SYMPTOMS
- ____ Headache
- ____ Fever
- ____ Chills
- ____ Night Sweats
- ____ Fainting
- ____ Dizziness
- ____ Convulsions
- ____ Loss of Sleep
- ____ Fatigue
- ____ Nervousness
- ____ Loss of Weight
- ____ Numbness or Pain in arms/legs/hands
- ____ Allergy (what?)
- ____ Wheezing
- ____ Neuralgia

RESPIRATORY
- ____ Chronic Cough
- ____ Spitting Blood
- ____ Spitting Phlegm
- ____ Chest Pain
- ____ Difficulty Breathing

GENITO-URINARY
- ____ Frequent Urination
- ____ Painful Urination
- ____ Blood in Urine
- ____ Kidney Infection
- ____ Bed Wetting
- ____ Inability to Control Urine
- ____ Prostate Trouble

EXERCISE
- ____ None
- ____ Moderate
- ____ Daily

HABITS
- ____ Smoking _____ packs/day
- ____ Coffee _____ cups/day
- ____ Alcohol

GASTRO-INTESTINAL
- ____ Poor Appetite
- ____ Poor Digestion
- ____ Excessive Hunger
- ____ Belching or Gas
- ____ Nausea
- ____ Vomiting
- ____ Vomiting Blood
- ____ Pain Over Stomach
- ____ Constipation
- ____ Diarrhea
- ____ Colon Trouble
- ____ Hemorrhoids (Piles)
- ____ Liver Trouble
- ____ Jaundice
- ____ Gall Bladder Trouble

MUSCLE & JOINTS
- ____ Weakness
- ____ Twitching
- ____ Stiff Neck
- ____ Backache
- ____ Swollen Joints
- ____ Tremors
- ____ Foot Trouble
- ____ Painful Tail Bone
- ____ Hernia
- ____ Spinal Curvature

SKIN OR ALLERGIES
- ____ Skin Eruptions
- ____ Itching
- ____ Bruising Easily
- ____ Dryness
- ____ Boils
- ____ Sensitive Skin
- ____ Hives or Allergies
- ____ Eczema
- ____ Medicines

EYE, EAR, NOSE, THROAT
- ____ Poor Vision
- ____ Crossed Eyes
- ____ Pain in Eyes
- ____ Deafness
- ____ Earache
- ____ Ear Noises
- ____ Ear Discharge
- ____ Nasal Obstruction
- ____ Nose Bleeds
- ____ Sore Throat
- ____ Hoarseness
- ____ Hay Fever
- ____ Asthma
- ____ Frequent Cold
- ____ Enlarged Thyroid
- ____ Tonsillitis
- ____ Sinus Trouble

CARDIO-VASCULAR
- ____ Rapid Heart
- ____ Slow Heart
- ____ High Blood Pressure
- ____ Low Blood Pressure
- ____ Pain Over Heart
- ____ Prev. Heart Trouble
- ____ Swelling of Ankles
- ____ Poor Circulation
- ____ Varicose Veins
- ____ Strokes

FOR WOMEN ONLY
- ____ Cramps or Back Ache
- ____ Painful Periods
- ____ Excessive Flow
- ____ Irregular Cycles
- ____ Hot Flashes
- ____ Cramps or Back
- ____ Miscarriage
- ____ Vaginal Discharge
- ____ Pregnant at Time
- ____ Last Pap
  Date _____
  By Whom _____

TURN OVER--> TURN OVER--> TURN OVER-->

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother					
Father					
Brother No. of _____					
Sister No. of _____					

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

_____ Appendicitis	_____ Anemia	_____ Heart Diseases	_____ Arthritis
_____ Pneumonia	_____ Measles	_____ Goiter	_____ Epilepsy
_____ Rheumatic Fever	_____ Mumps	_____ Influenza	_____ Mental Disability
_____ Polio	_____ Chicken Pox	_____ Pleurisy	_____ Lumbago
_____ Tuberculosis	_____ Diabetes	_____ Alcoholism	_____ Eczema
_____ Whooping Cough	_____ Cancer	_____ Venereal Infection	

OPERATIONS AND PROCEDURES

Vaccinations	_____	Tubes in Ears	_____	Sinus	_____
Tonsillectomy	_____	Appendectomy	_____	Hernia	_____
Gall Bladder	_____	Female Organs	_____	Thyroid	_____
Back Operations	_____	Rectal Surgery	_____	Stomach	_____

Other _____ please list type and date _____

ACCIDENTS OR FALLS

	Date	Please Explain
Car	_____	_____
Motorcycle	_____	_____
School	_____	_____
Work	_____	_____
Other	_____	_____
Broken Bones	_____	_____
Fractures	_____	_____
Dislocations	_____	_____

Have you ever had any spinal taps or spinal injections? _____
Have you ever been knocked unconscious? _____
Have you ever had a lapse of memory? _____

Are you presently taking any medications? (list) _____
_____
For what condition are you taking these? _____

Have you had x-rays taken in the past year? _____
For what condition were these pictures taken? _____

Are you now or have you ever been disabled from work? _____

Are you allergic to any medications? _____

*Note if you have a list of medications please give it to the office staff.