

Neuropathy Consult ROF

Please fill out the application entirely and legibly. We need all information for insurance purposes.

Name: _____ Nickname: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

We will need to contact you both by phone & email. Please be sure to give us the best phone number to reach you

Date of Birth: _____ Social Security: _____

If you have Medicare, we need you to list your SSN above or provide us with the Medicare card

Spouse Name: _____ Phone Number: _____

Your Occupation: _____ Retired: Yes No

REVIEW OF SYMPTOMS

Please check all that apply

- | | | |
|--|--|---|
| <input type="checkbox"/> Foot Pain | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Arthritis in Hands |
| <input type="checkbox"/> Hand Pain | <input type="checkbox"/> Bulging Disc | <input type="checkbox"/> Arthritis in Feet |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Spinal Stenosis | <input type="checkbox"/> Plantar Fasciitis |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Degenerative Disc | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Foot Numbness | <input type="checkbox"/> Vascular Problems | <input type="checkbox"/> Pinched Nerve |
| <input type="checkbox"/> Hand Numbness | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Morton's Neuroma | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Cancer | <input type="checkbox"/> Foot Surgery |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Poor Wound Healing |
| <input type="checkbox"/> Pacemaker/
Defibrillator | <input type="checkbox"/> Implanted Cord/
Bladder Stimulator | <input type="checkbox"/> Excessive Thirst or
Urination |

PRESENT HEALTH CONDITION

01 In order of importance, list the health problems you are most interested in getting corrected:

- 1. _____
- 2. _____
- 3. _____
- 4. _____

02 Is there a certain time of day any of these problems are better or worse?

03 Is your balance/walking ability affected? If yes, please describe:

07 Name of all doctors you have seen for these problems and treatment you received

04 List approximately how long you have noticed these problems in your life:

- 1. _____
- 2. _____
- 3. _____
- 4. _____

05 Circle the things you have used for these problems:

Gabapentin Neurontin Lyrica
Cymbalta Physical Therapy Pain Medications
Aleve Tylenol
Ibuprofen Motrin Chiropractic
Massage Therapy Injections Creams

06 What do you think is causing your problem?

08 Have your symptoms: Improved Worsened Stayed the Same

List anything that makes your condition worse _____

List anything that makes your condition better _____

09 How would you describe the symptoms? Please check ALL that apply:

- | | | |
|--|---|--|
| <input type="checkbox"/> Aching Pain | <input type="checkbox"/> Tingling/Electric Shocks | <input type="checkbox"/> Dead Feeling |
| <input type="checkbox"/> Stabbing Pain | <input type="checkbox"/> Pins & Needles Pain | <input type="checkbox"/> Cold Hands/Feet |
| <input type="checkbox"/> Sharp Pain | <input type="checkbox"/> Heavy Feeling | <input type="checkbox"/> Cramping |
| <input type="checkbox"/> Tiredness | <input type="checkbox"/> Hot Sensation | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Throbbing Pain | <input type="checkbox"/> Burning |

10 Is this condition interfering with any of the following?

- | | | |
|--|----------------------------------|---|
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Work | <input type="checkbox"/> Daily Activities |
| <input type="checkbox"/> Recreational Activities | <input type="checkbox"/> Walking | <input type="checkbox"/> Standing |

SOCIAL HISTORY

Do you smoke? Yes No If yes, how many cigarettes daily? _____

Do you drink? Yes No If yes, how many drinks per week? _____

Do you exercise? Yes No If yes, please describe type and how often? _____

CURRENT PAIN LEVELS

How would you rate your pain in the last week?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST POSSIBLE PAIN

If you had to accept some level of pain after completion of treatment, what would be an acceptable level

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST POSSIBLE PAIN

PREVIOUS HEALTH CONDITIONS

This is a confidential record of your medical history and pertinent personal information. The doctor reserves the right to discuss this information with medical and allied health professionals per the informed consent. Copies of this record can only be released by your written authorization, unless you sign here indicating that we can release copies by your verbal request.

Name: _____ **Signature:** _____

Please give name, address, and office phone number of your primary care physician.

Name: _____ **Phone:** _____ **Address:** _____

When were you last seen there? _____

May we send them updates on your treatment/condition? Yes No

List ALL allergies/sensitivities to medication, food, and other items here:

Items you react to:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____

List the prescription drugs you are currently taking (or you may attach a list):

Name	Dose (mg or IU)	Time Daily
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all nutritional supplements (vitamins, herbs, homeopathics, etc.) as above:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Quality of Life Survey

Company Information: _____

Name: _____ Date: _____

Please take several minutes to answer these questions so we can help you get better.
(Please check all that apply)

01 How have you taken care of your health in the past?

- | | |
|--|---|
| <input type="checkbox"/> Medications | <input type="checkbox"/> Nutrition/Diet |
| <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Holistic Care |
| <input type="checkbox"/> Routine Medical | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Chiropractic |
| <input type="checkbox"/> Other (please specify): _____ | |

02 How did the previous method(s) work out for you?

- | | |
|--|---|
| <input type="checkbox"/> Bad Results | <input type="checkbox"/> Did Not Get Worse |
| <input type="checkbox"/> Some Results | <input type="checkbox"/> Did Not Work Very Long |
| <input type="checkbox"/> Great Results | <input type="checkbox"/> Still Trying |
| <input type="checkbox"/> Nothing Changed | <input type="checkbox"/> Confused |

03 How have others been affected by your health condition?

- | | |
|--|---|
| <input type="checkbox"/> No One Is Affected | <input type="checkbox"/> They Tell Me To Do Something |
| <input type="checkbox"/> Haven't Noticed Any Problem | <input type="checkbox"/> People Avoid Me |

04 What are you afraid this might be (or beginning) to affect (or will affect)?

- | | |
|---|-----------------------------------|
| <input type="checkbox"/> Job | <input type="checkbox"/> Sleep |
| <input type="checkbox"/> Kids | <input type="checkbox"/> Time |
| <input type="checkbox"/> Future Ability | <input type="checkbox"/> Finances |
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Freedom |
| <input type="checkbox"/> Self-Esteem | |

05 Are there health conditions you are afraid this might turn into?

- | | |
|---|--|
| <input type="checkbox"/> Family Health Problems | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Need Surgery |
| <input type="checkbox"/> Arthritis | |

06 How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

07 What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.). Give 3 examples:

1.

2.

3.

08 What are you most concerned with regarding your problem?

09 Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.

10 What would be different/better without this problem? Please be specific.

11 What do you desire most to get from working with us?

12 What would that mean to you?

OFFICE FINANCIAL POLICY AND PATIENT CONSENT

If you have Insurance: By signing this form you are agreeing that you understand that all deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed \$100 or care may be terminated. Our payment plans make care an affordable part of your family budget. We do not accept assignment for or file claims for secondary insurance carriers, but will be happy to provide you with a proper receipt for your use. Our fees are considered usual, customary, and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area. If your

carrier has not paid a claim within 60 days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect payment in full. If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted. If your claim is for personal injury/auto, you understand that our office will accept a lien from your attorney and/or bill claims directly to your own auto insurance medpay benefit. We do not accept assignment from the responsible party's insurance. If you do not have any attorney or medpay coverage, you will be responsible for payment as service is rendered. X-RAYS: I understand that any x-rays performed in this office, remain the explicit property of this clinic. Maintenance/Wellness Care: When your schedule of visits is once per month or longer, you will not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered, or you may choose to be on our wellness payment plan.

Financial Policy/ Cash Patients: If you do not have insurance, all payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed \$100 at any time or care may be terminated. You further understand, that all billing fees and financial procedures as listed on this form, apply the same to you as those with insurance and you agree to such fully by signing below. Further, by signing below, I understand that if it is necessary for my account to be turned over to collections due to non-payment or late payment, that I will be responsible for all collection fees, attorney fees, and court costs associated with such collections. I also understand that if my account becomes delinquent, I will be charged billing fees of \$5 per statement, and interest at a rate of 1.75 percent per month on the unpaid balance.

Patient Consent: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physicians.

Release of Information: By signing this form, you are granting consent to Cleveland Non Surgical PC to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at 423-473-9700. You have the right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or healthcare operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Medicare and Medicaid Consent to Release Information: I certify that the information given by me in applying for payment under Title XVIII and/or Title XU if the Social Security Act is correct. I authorize any holder of medical or other information about me, to release the Social Security Administration or its intermediary carriers, any information needed for this or related to Medicare or Medicaid claim.

Verification of Non-Pregnancy (for female patients only): By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

Date of last menstrual period: _____

HIPPA Consent: I give permission for the individuals listed below to obtain my protected health information, and unless otherwise specified, the individuals may schedule and cancel appointments on my behalf or on behalf of my minor child. If this consent is for my minor child, it is also permission for listed individuals to bring my minor child to his/her appointments and as such is consent for the doctor to treat my minor child in my absence. I understand anyone not listed on this form will be denied ANY information, including information about my appointment times.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient's Printed Name: _____ Date: _____

Patient's Signature: _____