Bellevue Chiropractic Centre

Improving Function, Improving Life

Dr. William Walsh, DC and Dr. Bridget Walsh, DC

Clinic Policies

We believe that a clear definition of our clinic policies will allow us both to concentrate on the most important issue – your health. We will be happy to answer any questions you may have regarding our policies, your account, or insurance coverage.

Patient Payment Policy

Payment is expected at the time of service. Most insurance policies cover chiropractic care. We will be happy to file your primary and secondary insurance claims as a service to you. We cannot take responsibility for what your health insurance will or will not cover. Your co-pays and deductible payment are expected at the time of service. However, the patient's health needs are paramount, and, upon your request, our staff will arrange for payment plans if need be. Properly documented Worker's Compensation and auto accident claims are not required to be paid at the time of service.

Appointments

In order to better serve our patients, we ask that you call if you are unable to make your appointment or if you will be late.

Emergencies or After Hour Calls

In case of an emergency, you may contact the office for a special appointment any time during regular office hours. If you, a friend, or family member requires after hours or weekend assistance, you may call the clinic for special assistance.

Who is responsible for your bill?

___ Self ___Spouse ___Parent ___Insurance ___Worker's Comp ___Auto Insurance ___Medicare ___Medicaid

We welcome you to ask the doctors or staff about questions about your account or any aspect of your care. Getting you well is our primary concern.

I have read the Bellevue Chiropractic Centre Policies and will honor them.

_____ _____

Patient Signature Date

Insurance Information

Insurance Company Name _____ Phone Number _____

ID# _____ Group# _____

Name of Insured _____ Relationship _____self _____spouse _____parent

Insured's DOB _____ Insured's SS# _____

Insured's Phone # _____ Insured's Employer _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Bellevue Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctors to release all information to secure the payment of benefits. I authorize the use of my signature on all insurance submissions.

_____ _____

Responsible Party Signature Date

700 Lincoln Ave, Bellevue, PA 15202 | Phone: 412-766-5577 | Fax: 412-766-4350
Web: www.bellevuepachiro.com | Email: bellevuepachiro@gmail.com

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Consent for Use or Disclosure of Health Information

While the Health Insurance Portability & Accountability Act (HIPPA) requires us to give you this disclosure, please understand that we are very concerned with protecting your privacy and will always respect the privacy of your health information. Bellevue Chiropractic Centre may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding to us. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

Upon request, you may receive a copy of this authorization. This authorization will expire seven years after the date on which you last received services from us.

I authorize Bellevue Chiropractic to use or disclosure my health information in the manner described above.

_____	_____	_____
Patient Name Printed	Patient Signature	Date
_____	_____	_____
Personal Representative Printed	Personal Representative Signature	Description (parent, guardian, etc)

Bellevue Chiropractic Representative: _____

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Informed Consent in Doctor-Patient Relationship

Chiropractic

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy, and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, and physical and spinal conditions.

Analysis

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of spinal conditions. When spinal conditions are found, chiropractic adjustments and/or ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment and motion allows nerve transmission throughout the body and gives the body an opportunity to use its recuperative powers. Due to the complexities of nature, no doctor can promise you specific results.

Diagnosis

Although doctors of chiropractic are experts in chiropractic diagnosis, they are not internal medicine specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if s/he has any concerns as to the nature of their total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

Informed Consent for Chiropractic Care

A patient, in coming to a doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment and or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical deficits, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if s/he is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures whatever s/he is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnosis and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

Results

The purpose of chiropractic services is to promote natural health through the care and correction of spinal function. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal. In most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond different to the same chiropractic care. Many medical chiropractic cases may be controlled or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all the problems. Both have made great strides in alleviating pain and controlling disease.

Please discuss any questions or problems with the doctor before signing this statement of policy. I have read and understand the foregoing.

_____ _____

Patient Signature Date

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Informed Consent for E-mail Appointment Reminder

• I consent to Bellevue Chiropractic Centre contacting me by e-mail for the purpose of receiving appointment reminders.

• I acknowledge that appointment reminders by e-mail are an additional service, and the responsibility of attending appointments or changing them still rests with me. I understand that if I am not able to keep an appointment I will phone Bellevue Chiropractic Centre within 24 hours notice to change the appointment.

• E-mails are generated using a secure facility, but I understand that they are transmitted over a public network onto a personal device and, as such, may not be secure. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text or e-mail may be misdirected, disclosed to or intercepted by unauthorized third parties. Information included in e-mails may include your first name, date/time of appointments, name of physician, and physician phone number, or other pertinent information.

• All patients have the right to revoke this consent and have this service stopped. If you no longer wish to receive these reminders please notify our office at (412) 766-5577.

• The automated service does not offer a reply facility to enable patients to respond to e-mails directly.

• I agree to advise the practice if my e-mail changes or if this e-mail is no longer in my possession.

The e-mail address that I authorize to receive appointment reminder e-mails:

_____

I consent to receiving appointment reminders from Bellevue Chiropractic Centre at the e-mail provided.

_____

Patient Name (print)

_____ _____

Patient/Guardian Signature Date

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Web: www.bellevuepachiro.com | Email: bellevuepachiro@gmail.com

Confidential Patient Health Record

Personal History

Name: first _____ middle _____ last _____
Address: _____ City, State, Zip _____
Email: _____
Home Phone: _____ Work Phone: _____ Cell: _____
Business Employer: _____ Type of Work: _____
Social Security Number: _____ DOB: _____ Age: _____
Sex: F M *Circle one*: Single Married Widowed Divorced Separated
Spouses Name: _____
Spouse's SS#: _____ Spouse's DOB: _____
Spouse's Business Employer: _____ Type of Work: _____
Spouse's Business Phone Number: _____ Spouse's Cell: _____
Name & Ages of Children: _____
Name & Number of Emergency Contact: _____ Relationship: _____
Who referred you to our office? _____

Current Health Conditions

Purpose of this appointment: _____
Have you seen other doctors for this condition? ☐ yes ☐ no Who? _____
Type of treatment: _____ Results: _____
When did this condition begin? _____ Has this condition occurred before? _____
Is this condition: ☐ job related ☐ auto accident ☐ home injury ☐ fall ☐ other: _____
Date of accident: _____ Time of accident: _____
Have you made a report to your accident to your employer? ☐ yes ☐ no
Drugs you now take: ☐nerve pills ☐pain killers/muscle relaxers ☐blood pressure medicine
☐insulin ☐other:_____
Do you wear a shoe lift? ☐ yes ☐ no
Do you suffer from any condition other than the one you are consulting us about today? _____
_____

Past Health History

Major surgery/operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia
☐ Back Surgery ☐ Broken Bones ☐ Other _____
Major accidents/falls: _____
_____
Hospitalization (other than above): _____
_____
Previous Chiropractic Care: ☐ None ☐ Doctor's name and date of last visit: _____

Check any of the following diseases you have had:

☐Pneumonia	☐Pleurisy	☐Polio	☐Rheumatic Fever	☐Tuberculosis
☐Small Pox	☐Chicken Pox	☐Mumps	☐Measles	☐Whooping Cough
☐Arthritis	☐Eczema	☐Diabetes	☐Epilepsy	☐Cancer
☐Anemia	☐Mental Disorders	☐Lumbago	☐Heart Disease	☐Thyroid
☐Influenza				

Family History

The following have the same or similar problem as I do:
☐Mother ☐Father ☐Brother ☐Sister ☐Spouse Child

Check any of the following you have had in the past 6 months:

Musculo-Skeletal
- ☐ Low Back Pain
- ☐ Pain between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw

Nervous System
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

General
- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

CVR
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

Gastro-Intestinal
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating after Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

EENT
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

Genito-Urinary
- ☐ Bladder Trouble
- ☐ Discolored Urine
- ☐ Painful/Excessive Urination

Female/Male
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction

HIV Positive
☐ Yes ☐ No

Intake
☐ Coffee ☐ Tea
☐ Alcohol ☐ Cigarettes

Females Only:

Are you Pregnant? ☐ Yes Due Date: _____ When was your last period? _____
☐ No Please sign the following waiver.

I hereby notify all concerned that I neither suspect nor know positively at this time that I may be or am pregnant. I release this clinic from any and all damages arising from any and all procedures of a diagnostic or treatment nature with reference to the possibility of pregnancy.

_____ _____
Patient Signature Date

I hereby authorize the Doctor(s) to treat my condition as s/he deems appropriate through use of manipulation throughout my spine.

Patient Signature _____ Date _____

Parent or Guardian's Signature if Patient is under the age of 18 _____

Spouse or Personal Representative Signature if Patient is unable to sign _____

Activities of Daily Living Assessment

Rate your current difficulties by placing the appropriate number in the box.If an activity does not cause pain or if pain does not effect an activity, leave box blank.

[1] This activity causes some pain, but it is of minor annoyance.

[2] This activity causes a significant amount of pain.

[3] I cannot perform this activity due to pain and disability.

Self Care and Personal Hygiene

☐ bathing	☐ brushing teeth	☐ putting on shoes	☐ doing laundry	☐ grooming hair
☐ making bed	☐ putting on pants	☐ doing dishes	☐ washing face	☐ putting on shirt
☐ cooking	☐ taking out trash	☐ going to bathroom or sitting on toilet		

Physical Activities

☐ standing	☐ walking	☐ reaching	☐ bending right	☐ twisting right
☐ sitting	☐ squatting	☐ bending	☐ bending left	☐ twisting left
☐ reclining	☐ bending back	☐ kneeling	☐ looking left	☐ looking right

Functional Activities

☐ carrying small objects	☐ lifting weight off table	☐ push/pull standing	☐ carrying large objects	☐ climbing stairs/incline
☐ exercising upper body	☐ exercising lower body	☐ carrying purse/case	☐ lifting objects off floor	☐ push/pull seated

Social & Recreational Activities

☐ jogging	☐ biking	☐ swimming	☐ dancing	☐ golfing
☐ bowling	☐ hunting	☐ fishing	☐ gardening	☐ basketball
☐ soccer	☐ hockey	☐ competitive sports		

Difficulties with Travel

☐ driving in car	☐ riding as passenger	☐ entering and exiting vehicle	☐ driving for long periods of time
☐ riding as passenger for long period of time			

Other Activities

☐ concentrating	☐ studying	☐ listening	☐ reading	☐ writing
☐ using computer	☐ sleeping	☐ sexual relation		

Patient Name: Date: Score:

Quadruple Numerical Rating Scale

Patient Last Name	Patient First Name	Patient ID	Date of Birth (MM/DD/YYYY) _____/_____/_____
Provider Last Name	Provider First Name	Provider Phone (area code first)	

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain _____ worst possible pain

0 1 (2) 3 4 (5) 6 7 (8) 9 10

1. What is your pain **RIGHT NOW**?

No pain _____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

2. What is your **TYPICAL** or **AVERAGE** pain?

No pain _____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level **AT ITS BEST** (How close to "0" does your pain get at its best)?

No pain _____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level **AT ITS WORST** (How close to "10" does your pain get at its worst)?

No pain _____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature _____ Date _____

Neck Disability Index

This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the one box that applies to you. We realise you may consider the two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1: Pain Intensity

- I have no pain at the moment.
- The pain is mild at the moment.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain is very severe, but comes and goes.
- The pain is severe and does not vary much.

SECTION 2: Personal Care (e.g. washing, dressing)

- 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 can manage most of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, 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 me extra pain.
- Pain prevents me from lifting heavy weights off the floor I can manage if they are conveniently placed (e.g., 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 only lift very light weights.
- I cannot lift or carry anything.

SECTION 4: Reading

- I can read as much as I want to with no neck pain.
- I can read as much as I want with slight neck pain.
- I can read as much as I want with moderate neck pain.
- I cannot read as much as I want because of moderate neck pain.
- I cannot read as much as I want because of severe neck pain.
- I cannot read at all.

SECTION 5: Headache

- I have no headaches at all.
- I have slight headaches which come infrequently
- I have moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

SECTION 6: Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

SECTION 7: Work

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I cannot do any work at all.

SECTION 8: Driving

- I can drive my car without neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I cannot drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive my car at all because of severe pain in my neck.
- I cannot drive my car at all.

SECTION 9: Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hour sleepless).
- My sleep is mildly disturbed (1-2 hours sleepless).
- My sleep is moderately disturbed (2-3 hours sleepless).
- My sleep is greatly disturbed (3-5 hours sleepless).
- My sleep is completely disturbed (5-7 hours sleepless)

SECTION 10: Recreation

- I am able to engage in all recreational activities with no pain in my neck at all.
- I am able to engage in all recreational activities with some pain in my neck.
- I am able to engage in most, but not all, recreational activities because of pain in my neck.
- I am able to engage in a few of my usual recreational activities because of pain in my neck.
- I can hardly do any recreational activities because of pain in my neck.
- I cannot do any recreational activities at all.

Patient Name: Date: Score:

Oswestry Low Back Pain Disability Questionnaire

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

SECTION 1: Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

SECTION 2: Personal Care (e.g. washing, dressing)

- 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 can manage most of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, 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 me extra pain.
- Pain prevents me from lifting heavy weights off the floor I can manage if they are conveniently placed (e.g., 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 only lift very light weights.
- I cannot lift or carry anything.

SECTION 4: Walking

- Pain does not prevent me walking any distance.
- Pain prevents me from walking more than 1 mile.
- Pain prevents me from walking more than 1/2 mile.
- Pain prevents me from walking more than 100 yards.
- I can only walk using a stick or crutches.
- I am in bed most of the time.

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 sitting more than 1 hour.
- Pain prevents me from sitting more than 30 minutes.
- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting at all.

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 me extra pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing for more than 30 minutes.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

SECTION 7: Sleeping

- My sleep is never disturbed by pain.
- My sleep is occasionally disturbed by pain.
- Because of pain I have less than 6 hours sleep.
- Because of pain I have less than 4 hours sleep.
- Because of pain I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

SECTION 8: Sex Life (if applicable)

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

SECTION 9: 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. sport.
- 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 10: Traveling

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

Patient Name: Date: Score: