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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Patient Responsibility – Insurance Disclaimer

Insurance Disclaimer: A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service.

Insurance Liability for Payment: Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company, when applicable. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service.

Under this arrangement, you are responsible for paying your co-pay, any non-covered portions, any co-insurance, and/or any deductible you have yet to cover. In addition, if your insurance company does not pay for our services, you agree to pay for the services provided in our office.

Beneficiary Agreement: I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

_____ _____

Printed Name Signature

_____ _____

Date Date of Birth

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 _____

Yellow Flags Questionnaire (YFQ)

Name: **Date:**

Please circle the appropriate response for each of the following statements or questions:

1. Please indicate your usual level of pain during **the past week**:	**No Pain** 0 1 2 3 4 5 6 7 8 9 10 **Worst Possible Pain**
2. Does pain, numbness, tingling or weakness extend into your leg (from the low back) &/or arm (from the neck)?	**None Of The Time** 0 1 2 3 4 5 6 7 8 9 10 **All Of The Time**
3. How would you rate your general health?	**Poor** 0 1 2 3 4 5 6 7 8 9 10 **Excellent**
4. If you had to spend the rest of your life with your condition as it is right now, how would you feel about it?	**Delighted** 0 1 2 3 4 5 6 7 8 9 10 **Terrible**
5. How anxious (tense, uptight, irritable, fearful, difficulty in concentrating / relaxing) you have been feeling during **the past week**:	**Not At All** 0 1 2 3 4 5 6 7 8 9 10 **Extremely Anxious**
6. How much you have been able to control (reduce/help) your pain/ complaint on your own during **the past week**:	**I Can Reduce It** 0 1 2 3 4 5 6 7 8 9 10 **I Can't Reduce It At All**
7. Please indicate how depressed (eg. Down-in-the-dumps, sad, downhearted, in low spirits, pessimistic, feelings of hopelessness) you have been feeling in **the past week**:	**Not Depressed At All** 0 1 2 3 4 5 6 7 8 9 10 **Extremely Depressed**
8. On a scale of 0 to 10, how certain are you that you will be doing normal activities or working in **six months**?	**Very Certain** 0 1 2 3 4 5 6 7 8 9 10 **Not Certain At All**
9. I can do light work for an hour.	**Completely Agree** 0 1 2 3 4 5 6 7 8 9 10 **Completely Disagree**
10. I can sleep at night.	**Completely Agree** 0 1 2 3 4 5 6 7 8 9 10 **Completely Disagree**
11. An increase in pain is an indication that I should stop what I am doing until the pain decreases.	**Completely Disagree** 0 1 2 3 4 5 6 7 8 9 10 **Completely Agree**
12. Physical activity makes my pain worse.	**Completely Disagree** 0 1 2 3 4 5 6 7 8 9 10 **Completely Agree**
13. I should not do my normal activities including work with my present pain.	**Completely Disagree** 0 1 2 3 4 5 6 7 8 9 10 **Completely Agree**
	Patient Signature: _____