

# *Graybar Chiropractic & Rehab Centers*

## **Re-Activation of an Established Patient**

Dear Patient,

I acknowledge that **there has been a new condition or exacerbation of a prior condition resulting in the pain for which I am seeking treatment today.** I fully understand the medical necessity of this present condition. I am choosing to begin care adhering to the treatment program that the doctors will develop for me. I also acknowledge that I understand the differences between **“Medically Necessary” vs. “Clinically Appropriate”** as explained below.

Due to changes in the treatment of your present symptomology and in following the insurance guidelines for treating your present condition, it is extremely important that you understand the difference between **“Medically Necessary” vs. “Clinically Appropriate”**.

**“Medically Necessary”**: Insurance carriers define this as treatment or service that is specific to your diagnosis and which will be paid for per your contract with them. The insurer only pays for chiropractic care that has a direct connection to documented improved function. There may be specific limits to your coverage or specific services that are not covered and this also is determined by your carrier.

**“Clinically Appropriate”**: For example, if you have a neck or lower back condition, your treatment plan may have to be extended beyond the insurance company’s standardized limitations in order to provide you full pain relief. At some point later in your treatment, we may not be able to document significant improvements in range of motion or other objective functional capacity measurements as the insurers often require. Insurance companies often deny care at that point despite the fact that the treatment continues to manage, reduce or eliminate your pain. This is “clinically appropriate” for your circumstances, but may not be considered “medically necessary” by your insurance carrier.

I have been informed of and accept the responsibility of being fully and personally responsible for all charges incurred for my care either not covered by my insurance carrier or which my carrier denies as not medically necessary.

My signature below acknowledges that I fully have read and understand the treatment options available to me with Graybar Chiropractic & Rehab Centers.

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Today’s Date: \_\_\_\_\_

### **Office Use only:**

Re-Activation -  Old /  New Condition \_\_\_\_\_  
 New Injury Date \_\_\_\_\_

Doctor Signature: \_\_\_\_\_ Today’s Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Insurance Co. : \_\_\_\_\_ Policy #: \_\_\_\_\_

Changes in Medical History since last visit ( Surgery, Auto Accident etc...): \_\_\_\_\_

Symptom(s) for seeking treatment today: \_\_\_\_\_

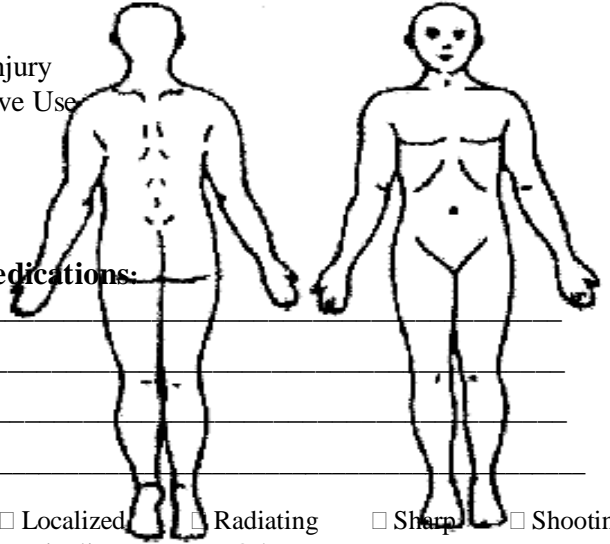
When did this problem begin (Actual Date)? \_\_\_\_\_

Has it ever occurred before?  Yes  No When? \_\_\_\_\_ A=Ache B=Burning N=Numbness P=Pins & Needles S=Stabbing

PLEASE LABEL THE AREA OF DISCOMFORT

Cause of injury:  Auto Related  Job Related  Home Injury  
 Slip or Fall  Lifting  Slept Wrong  Overexertion  Repetitive Use  
 Other – No Liability:  Unknown

Explain: \_\_\_\_\_



Prior treatment for this condition (other doctors), including medications:

If yes, who? When? (Name) Type of Treatments: \_\_\_\_\_

Explain: \_\_\_\_\_

Location and radiation of symptoms: Left / Right / Bilateral \_\_\_\_\_

Quality of Pain:  Burning  Diffuse  Dull/Aching  Localized  Radiating  Sharp  Shooting  
 Stabbing  Throbbing  Tightness  Tingling  Other \_\_\_\_\_

Severity of Pain: (With Activity) 10 - worst  0  1  2  3  4  5  6  7  8  9  10

Duration of symptoms:  \_\_\_ day(s)  \_\_\_ week(s)  \_\_\_ month(s)  \_\_\_ year(s)  other \_\_\_\_\_

Frequency of symptoms occurring:  Constant (67-100%/day)  Frequent (33-66%/day)  Occasional (0-32%/day)

Intensity:  Mild  Mild/Moderate  Moderate  Moderate/Severe  Severe

Timing: Better:  Morning  Afternoon  Night Worse:  Morning  Afternoon  Night

Symptoms Better With:  nothing helps  activity  bending  applying cold  applying heat  
 massage  movement  OTC meds  Rx meds  rest  
 stretching  sitting  standing  twisting  walking  \_\_\_\_\_

Symptoms Worse With:  nothing helps  activity  bending  applying cold  applying heat  
 massage  movement  OTC meds  Rx meds  rest  
 stretching  sitting  standing  twisting  walking  \_\_\_\_\_

### Daily Activities: Effects of Current Condition on Performance

Sleep:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
Walking:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
Constant Sitting:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
Constant Standing:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
Change Posn–Sit–Stand:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
Turning the Head:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
Driving:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
Self Care:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
Bending:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
Rendering Child Care:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
Lifting (at home):  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform  
Extended Computer Use:  No Effect  Mild Painful (Can do)  Mod Painful (Limited)  Sev Unable to Perform

**Graybar Chiropractic & Rehab Centers**  
**Confidential Health Record**

**Wallace 116 N. Norwood Street**  
**Wilmington 2110 S. 17<sup>th</sup> Street**  
**Clinton 600 Beaman Street**

*How did you hear about us?*    Radio    Television    Yellow pages    Office Sign    Insurance Plan  
 Family \_\_\_\_\_    Friend \_\_\_\_\_    Prior patient    Newspaper  
 Co-Worker \_\_\_\_\_    Dr. \_\_\_\_\_    Billboard    \_\_\_\_\_

***Personal Information***

***Today's Date:***

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_ Sex: Male / Female  
Address: \_\_\_\_\_ Apt # \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_ Country: \_\_\_\_\_  
Home Phone : (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Carrier \_\_\_\_\_  
Status:  Single  Married  Divorced  Widowed  Separated   **Birth Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_   **Age:** \_\_\_\_  
Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_   Fax #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Driver's License #: \_\_\_\_\_ State: \_\_\_\_\_   Email Address: \_\_\_\_\_  
Spouse Name: \_\_\_\_\_   Children (Names and Ages): \_\_\_\_\_

***Emergency Contact***

**Name:** \_\_\_\_\_   **Phone Number:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
**Address:** \_\_\_\_\_   Relationship:  Spouse  Relative  Friend  Other \_\_\_\_\_

***Employment Information – Job description***

RETIRED    DISABLED    UNEMPLOYED

Business Name: \_\_\_\_\_   Occupation/Job Title: \_\_\_\_\_  
Business Address: \_\_\_\_\_   Name of Supervisor: \_\_\_\_\_  
Business Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_   Type of Work: \_\_\_\_\_   Work: \_\_\_\_ hrs/day or \_\_\_\_ per week  
Job Classification:    Sedentary (<5lbs)    Light (5-20lbs)    Moderate (20-50lbs)    Heavy (>50 lbs)  
Lifting Frequency:  Constant (67-100%/day)    Frequent (33-66%/day)    Occasional (0-32%/day)

**Insurance Information:**

Who is responsible for your bill?   YOU and... (Mark appropriate box(es))    Myself ONLY    Spouse

Worker's Comp    Auto Insurance    Medpay claim    Medicare    Medicaid    Other (be specific): \_\_\_\_\_

Personal Health Insurance Carrier: \_\_\_\_\_   Health ID card #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_   Group #: \_\_\_\_\_

Policy Holder's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_   Policy Holder's Birthday Date: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_   Carolina Access Number: \_\_\_\_\_

Workers Compensation Injury / Auto / Personal Injury   *Have you filed an injury report*    Yes    No

Carrier: \_\_\_\_\_   Policy # \_\_\_\_\_

Carriers Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_   Adjuster: \_\_\_\_\_

Claim #: \_\_\_\_\_   Date: \_\_\_\_/\_\_\_\_/\_\_\_\_   Time: \_\_\_\_\_ am/pm