FRAME CHIROPRACTIC

2034 E. Southern Ave, Suite J Tempe, Arizona 85282 Phone: 480.345.2080 Fax: 480.820.5065

∞ W E L C O M E ∞

ABOUT YOU (please print)

Today's Date: _____
Patient Name: _____
DOB: _____ Age: _____ SS#:_____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Home Phone #: _____ Cell Phone #: _____
Work Phone #: _____ EXT #: _____
Minor___ Single___ Married___ Divorced___ Separated___ Widowed___
Spouse's Name: _____
Do you have any children: Yes___ No___ How many: _____
Referred By: _____

Employer: _____
Address: _____
City: _____ State: _____ Zip: _____
Occupation: _____

REASON FOR VISIT (please print)

The reason for this visit is a result of (circle one): **WORK SPORTS AUTO TRAUMA CHRONIC**
(Explain what happened):_____
_____
Explain the pain and location: _____
_____
When did it begin: _____ Is it getting worse: Yes___ No___ Other_____
Is this condition interfering with your: (circle one): **WORK SLEEP DAILY ROUTINE**
If so, please explain: _____
Have you been treated by a Medical Physician for this condition: Yes___ No___
If so, where? _____
Have you ever been treated by a Chiropractor before? Yes___ No____
If so, whom? _____ Phone #: _____

IN THE EVENT OF EMERGENCY(please print)

Who should we contact? _____
Relation: _____
Home Phone #:_____ Cell #:_____
Who is you Medical Doctor? _____ Phone #: _____

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HEALTH HISTORY (please print)

Are you taking any of the following medications?

- ❑ Nerve Pills
- ❑ Pain Killers (including aspirin)
- ❑ Muscle Relaxers
- ❑ Stimulants
- ❑ Tranquilizers
- ❑ Blood Thinners
- ❑ Other_____
  _____
  _____
  _____
  _____
- ❑ Insulin

Do you or have you ever had any of the following conditions (check all that apply)?

❑Heart Attack / Stroke	❑Heart Surg. / Pacemaker	❑Heart Murmur
❑Congenital Heart Defect	❑Mitral Valve Prolapse	❑Hepatitis
❑Alcohol / Drug Abuse	❑Venereal Disease	❑Cancer
❑HIV+ / Aids	❑Shingles	❑Anemia
❑Frequent Neck Pain	❑Emphysema / Glaucoma	❑Rheumatic Fever
❑High/Low Blood Pressure	❑Psychiatric Problems	❑Ulcers / Colitis
❑Severe / Frequent Headaches	❑Kidney Problems	❑Asthma
❑Fainting / Seizures Epilepsy	❑Sinus Problems	❑Chemotherapy
❑Diabetes / Tuberculosis	❑Difficulty Breathing	❑Arthritis
❑Lower Back Problems	❑Artificial Bones / Joints	

Please list any other serious medical condition(s) you have or ever had: _____
_____

List previous surgeries/treatments with dates: _____
_____

List any **past** serious accidents with dates: _____
_____

Family Health History: _____
_____

Do you: Take Supplements or Vitamins? Yes___ No___ Exercise? Yes___ No___
Are you on a special diet: Yes___ No___ Since: _____
Do you smoke? Yes___ No___ How much? _____ How long? _____
Are you wearing: Heels Lifts___ Sole Lifts___ Inner Soles___ Arch Support___
What is the age of your mattress? _____ Is it comfortable? Yes___ No___
For Women: Are you taking Birth Control? Yes___ No___
Are you pregnant? No___ Yes/How Long? _____ Nursing: _____

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Worker's Compensation Questionnaire
(Please Print Clearly)

Accident Information

Last Name: _____First Name: _____M.I.: ____
Date of accident:____/____/____ Time: ___:___ am pm
Name and address of the location your injury took place at: _____
_____
_____
Street Suite/Apt# City, State Zip

I am **RIGHT LEFT** Handed. (please circle)
Were you hospitalized for this injury? ☐NO ☐YES

Name of Hospital: _____
Date you were hospitalized: ____/____/____ Date of discharge: ____/____/____
Treatment received: _____

Did you see any other doctors for your injuries? ☐NO ☐YES

Name of doctor: _____
Type of doctor: D.C. M.D. D.O. Other: _____
Treatment received: _____

Please list your complaints and areas of pain in detail: _____
_____
_____
Where did you feel symptoms (in body) immediately after the injury? _____
_____
Please describe how your **BODY FELT** and your **PHYSICAL CONDITION**:

DURING the accident: _____
IMMEDIATELY AFTER the accident: _____
LATER that day: _____
THE NEXT day: _____

Do you have any existing impairment(s) affecting your present condition? ☐NO ☐YES

Are you able to do the *same* type of work you preformed at the time of injury? ☐NO YES

Are you able to do a *lighter* type of work you preformed at the time of injury? ☐NO YES

Before this injury, were you capable of working on an equal basis with others your age? ☐NO YES

Have you ever injured this area before? ☐NO YES,

If yes, When? ____/____/____
Did you fully recover from this injury? ☐NO YES

Since this injury are your symptoms: ☐ Getting Worse ☐ The Same ☐ Improving

Did you report this accident to your supervisor? ☐NO ☐YES (if no, please report ASAP)

In your work, do you need to favor any body part(s)? ☐NO YES

If yes, list: _____

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Attorney & Witness Information

Were there any witnesses? ☐NO ☐YES

Witness Name: _____ Phone: (_____)_____
Have you retained an attorney? ☐NO ☐YES

If yes, attorney name/firm: _____
Address: _____ Phone: (_____) _____
Please notify your attorney that you have chosen Dr. Paul E. Frame, D.C. & do not wish to be referred elsewhere.

Please check all that apply

☐ Headaches	☐ Irritability	☐ Numbness in toes	☐ Buzzing in Ears
☐ Neck pain	☐ Chest pain	☐ Shortness in breath	☐ Faced Flushed
☐ Neck stiff	☐ Dizziness	☐ Fatigue	☐ Loss of balance
☐ Upper-back pain	☐ Head seems heavy	☐ Depression	☐ Fainting
☐ Mid-back pain	☐ Sensitivity to light	☐ Loss of taste	☐ Difficulty Sleeping
☐ Low-back pain	☐ Ringing in Ears	☐ Loss of memory	☐ Nervousness
☐ Shoulder pain	☐ Stomach Ache	☐ Cold hands	☐ Sleeping problems
☐ Arm Pain	☐ Loss of smell	☐ Tension	☐ Pins/Needles in *legs*
☐ Leg pain	☐ Visual Weakness	☐ Diarrhea	☐ Numbness in *fingers*
☐ Cold feet	☐ Constipation	☐ Cold sweats	☐ Pins/Needles in *arms*
☐ Fever	☐ Other: _____		

Family Medical History: **PLEASE CHECK ALL THAT APPLY**

☐ Cancer	☐ Stroke	☐ Seizures	☐ Diabetes	☐ Osteoporosis
☐ Abnormal Blood Pressure		☐ Cardiovascular Disease		☐ Other: _____

Work Related Information

Do you notice any restrictions as a result of this accident? ☐ NO ☐ YES

If yes, describe: _____
Your occupation: _____ ☐ Part-time ☐ Full-time

Have you lost time from work as a result of this injury? ☐ NO ☐ YES

If yes, what dates were you unable to work? ____/____/___ through ___/____/___
Are you being compensated for time lost from work? ☐ NO ☐ YES

By signing below, I hereby certify the above information is complete and accurate to the best of my knowledge. Inaccurate information could be dangerous to my health.

_____ _____ ____/____/____
Signature of Patient/Guardian Print Name Date

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

It is important that each patient understand both the objective and the method that will be used to attain it.

Your nervous system is made up of your brain, spinal cord & nerves. Your nervous system is in charge of directing, controlling, & coordinating every organ & system in your body. If you have a misaligned spinal or extremity bone, the nerves exiting through that bone are not operating at their best. I detect this, then gently and manually perform adjustments to remove nervous system interference. Once adjusted the nerve tracts are no longer compressed & your nervous system can work at its optimum. Ultimately homeostasis & health are restored naturally to every organ, system, tissue, & cell in your body.

Extremity Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral and extremity subluxation. Our chiropractic method of correction is by specific adjustments of the spine and extremities.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Extremity Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column and extremity joints which causes alteration of nerve function and interference to the transmission of impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

-Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct subluxation.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(signature) (date)

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ASSIGNMENT OF BENEFITS

I authorize Dr. Paul E. Frame, D.C., to receive direct payment from my insurance company(s) or attorney for all moneys due on my account. I understand that all coverages in effect will be billed and collected from, including group(s), medical payments and attorney liens.
Any overpayments will be promptly returned.

In the event that there is no valid coverage or that I have exceeded my annual insurance limit, I will remain responsible for all charges incurred. I agree to provide Dr. Paul E. Frame, D.C. with all valid insurance information forms and billing information within 5 days of my first visit.

Should I receive payments or settlements for services rendered, I agree to forward these to Dr. Paul E. Frame, D.C. within 5 days of receiving such materials.

I acknowledge that the assignment terms and fees have been reviewed with me and I agree to all of the above terms.

_____ _____
Signature (Patient) Date
(or legal guardian if applicable)

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FEE SCHEDULE APPLIED TO ALL INSURANCE COMPANIES

Usual and Customary Fees for Frame Chiropractic

Initial Examination: (1st & 2nd Visits) $60.60-$210.60
Patient conference, detailed review of case history, extended palpatory spinal examination, orthopedic & neurologic examination, correlation of findings. report of radiographic findings, doctor's recommendations, and introduction of care plan.

Intermediate Examination: $60.00-$77.40
A correlation of past and present findings with extended discussion of patient' s health as a result of care to date to determine extent and frequency of continued care of dismissal. Includes examination procedures described above.

Spinal X-Rays/2 Views: (when deemed necessary)
$100.00
If radiographic films are taken, law requires all health care facilities to take a minimum of 2 (opposing) views.

Adjustment: $44.40-$73.80
A specific manual (by hand) or instrumental adjustment to correct Subluxations (a misalignment of a spinal/extra spinal joint causing nerve interference).

Heat or Ice Therapy: (as deemed necessary) $25.00
A pack used for the reduction of muscle spasm and inflammation.

Interferential Current: (as deemed necessary) $40.00
Electrical stimulation directed to muscles used for the reduction of inflammation.

Manual Therapy: (as deemed necessary) $65.00
Manual traction therapy for stretching spinal joints/musculature to increase mobility and/or sustained pressure either instrumental or manual for increasing range of motion, reducing muscle spasm, avoiding scar tissue formation, and promotion of the healing process (based on 8-15 minute increments).

Therapeutic Exercise: (as deemed necessary and based on 8-15 minute increments). $65.00

Patient Name (Printed):

_____

Patient Signature:

_____

Today's Date: _____ Witness: _____

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NOTICE TO INSURANCE COMPANY OF ASSIGNMENT
AUTHORIZATION TO ISSUE CHECKS AND DRAFTS TO DOCTOR

To: _____

Insurance Company responsible for payment

1. I, _____ ID#_____,
   Patient's Name
   do hereby **AUTHORIZE AND DIRECT** any and all checks or drafts relative to treatment rendered by Dr. Paul E. Frame, D.C., which are issued by the above named insurance company, and which represent sums payable to me, the patient, or on my behalf be made payable to the order of:
   Dr. Paul E. Frame, D.C.
   3330 South Price Road, Suite D-110
   Tempe, Arizona 85282
   I authorize all relative health care payments be made out to doctor and forwarded to doctor's office.
2. I further **AUTHORIZE AND DIRECT** you to send all of said checks or drafts to:
   Dr. Paul E. Frame, D.C.
   3330 South Price Road, Suite D-110
   Tempe, Arizona 85282
3. I further **AUTHORIZE AND DIRECT** Dr. Paul E. Frame, D.C. to provide care to me and to release all of my health care information necessary for the processing and payment of any health insurance claim he submits in relation to my care.
4. I understand Dr is providing care and waiting for reimbursement from the insurance company as a service to me. In order for this service to continue I hereby grant, Dr. Paul E. Frame, D.C., Power of Attorney to negotiate any draft or check amount for the services rendered by Dr. Paul E. Frame, D.C.'s office. In the event the insurance company denies payment, Dr. Paul E. Frame, D.C. may retain the unpaid balance of his bill for all care provided to me in this office, through small claims court, at 100% of his billing. Any amount paid the put of pocket for relative dates of service will be forwarded to me, the patient, directly, after the doctor's bill has been satisfied in full.
5. Our office will make every effort to collect from he insurance company. Our success rate is excellent. However, if these efforts are exhausted, and the services of a collection agency become necessary, I understand I will be responsible for the agency fees at thirty percent of my total bill (the insurance company will be billed first).

In the event any insurance company obligated by contracted agreement to make payment to me or to Dr. Paul E. Frame, D.C., refuses to make such payment upon demand by Dr. Paul E. Frame, D.C., hereby agree to sign a small claims action at that time, or personally reimburse the doctor and pay my balance in full at that time. If Dr. Paul E. Frame, D.C. is not reimbursed within a reasonable amount of time from the date of dismissal from this office, or if I do not reimburse him directly and pay my balance in full, I hereby assign and transfer Dr. Paul E. Frame, D.C., the cause of action that exists in my favor against any such insurance company, and authorize Dr. Paul E. Frame, D.C. to prosecute said action, either in my name or the insurance company's name, and further authorize Dr. Paul E. Frame, D.C. to file a lien and collect on his said portion of the claim for amount of services he provides.

By signing below the co-payment of care would be a financial hardship to me:
Witness: _____
A copy of this form shall be sent to all payers & copies shall be as valid as the original

_____ _____ ____/____/____

Signature of Patient/Guardian **Print Name** **Date**