INSURANCE PROCEDURES AND VERIFICATION OF BENEFITS DISCLAIMER

The office of Dr. Michael A. Miller, DC & Dr. Adam Z. Miller, DC, will verify your health insurance benefits as a courtesy if time permits, and submit your health insurance claims if you have the Chiropractic benefits on your health plan. Please be aware, however, that we can only accept assignment on your insurance when coverage has been determined.

Verification of benefits are **NOT** a guarantee of payment and are subject to all specific plan provisions and restrictions. You will be responsible for all uncovered services as they are rendered.

Our office policy with the insurance carriers is to collect any co-payments or co-insurance charges as services are rendered.

If you have any questions, please do not hesitate to ask our staff at any time.

I have read and understand the insurance procedures and benefits verification disclaimer above.

Signature **Date**

Date _____/_____/_____

New Patient Information Worksheet

Please fill out information completely to insure proper billing.

First _____Middle _____
Last _____
Street _____
City _____State _____ Zip _____
Home Phone _____
Work Phone _____
Cell Phone _____

SS# _____
Date of Birth _____
Marital Status S M D W
Spouse _____

E-MAIL ADDRESS _____

Case

Please fill in applicable fields

Billing Status: Cash Insurance

Billing Profile: CASH AUTO WC
BCBS TUFTS HPHC
MEDICARE GENERAL INS

Employment Information:

Occupation _____
Employer _____
Employer Address/Phone # _____
City _____ State _____Zip _____

Insurance Subscriber Information

First _____
Last _____
Street _____
City _____ State _____ Zip_____

Employer _____

Relationship to patient Self Spouse Parent

Primary Insurance Company

(This is your health insurance) (If you are auto or workers comp case, please list your auto or employers insurance company)

ID# or Claim # _____
Group # _____

Insurance Company Name _____
Insurance Company Address _____
Phone _____ Fax _____

Secondary Insurance Company

(This is the health insurance if applicable when primary is auto … Or this would be a secondary health carrier)

ID# or Claim # _____
Insurance Company Name _____
Insurance Company Address _____

Attorney Information

Name _____
Address _____
Phone _____

Your right to complain

You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights, we respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to:

Dr. Michael A. Miller, DC, CCSP, PC
Dr. Adam Z. Miller, DC
884 Washington Street, Norwood MA 02062

This notice is effective as of January 2016. This notice will expire seven years after the date upon which the record was created. Buy signing below, I acknowledge that I have received a copy of this notice.

Patient name (printed) Date

Patient Signature Authorized Provider Representative

Privacy Notice Acknowledgement

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient, if you ever have any questions or concerns regarding the use of dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Dr. Michael A. Miller, DC, CCSP, PC, notice of Privacy Practices for Protected Health Information.

Patient Name (printed) Date

MILLER
CHIROPRACTIC OFFICES, P.C.

Dr. Michael A. Miller, D.C., CCSP, CCRD, P.C.
Certified Chiropractic Sports Physician
884-H Washington Street / Norwood / Mass. / 02062
Tel: (781) 762-5600
Fax: (781) 769-2100

INFORMED CONSENT – NEW PATIENTS

This is to acknowledge that the patient whose signature appears below has given permission to Dr. Michael A. Miller, DC, CCSP, CCRD, PC, and/or Dr. Adam Z. Miller, DC, a licensed Chiropractor in the state of Massachusetts, to perform any diagnostic or therapeutic procedure that he deems appropriate. Prior to performing such examination, Dr. Michael A. Miller, and/or Dr. Adam Z. Miller, DC, will inform the patient as to the procedures to be followed, and any benefits or risks associated with this procedure and/or consequent treatment. By supplying the patient with all significant clinical information, the patient should be able to decide whether or not to undergo the proposed treatment or procedure.

_____
Patient Name

_____
Patient Signature Date

_____
Guardian Signature Date
(If patient is under 18 years of age)

MILLER
CHIROPRACTIC OFFICES, P.C.

Dr. Michael A. Miller, D.C., CCSP, CCRD, P.C.
Certified Chiropractic Sports Physician
884-H Washington Street / Norwood / Mass. / 02062
Tel: (781) 762-5600
Fax: (781) 769-2100

Date:_____

To: _____

I HEREBY AUTHORIZE THE RELEASE OF X-RAYS/CT SCAN/MRI/MEDICAL RECORDS.

THESE FILMS/REPORTS WERE TAKEN ON: _____

NAME OF PATIENT:_____

DATE OF BIRTH:_____

ADDRESS:_____

_____

SIGNATURE:_____

OUR FAX # IS **781-769-2100**. PLEASE FAX US THE ABOVE RESULTS AT YOUR EARLIEST CONVENIENCE.

THANK YOU.

Oswestry Pain Questionnaire

Barcode #:

Name: _____ Today's Date: _____

10. Pain Intensity:

- ☐ 0 I have no pain.
- ☐ 1 Pain comes and goes and is very mild.
- ☐ 2 Pain is constant and is very mild.
- ☐ 3 Pain comes and goes and is moderate.
- ☐ 4 Pain is constant and is moderate.
- ☐ 5 Pain is constant and is severe.

20. Personal Care:

- ☐ 0 I look after myself normally w/o causing extra pain.
- ☐ 1 I look after myself normally but it causes extra pain.
- ☐ 2 It's painful looking after myself; I am slow/careful.
- ☐ 3 I need help but manage most of my personal care.
- ☐ 4 I need help every day in most aspects of self-care.
- ☐ 5 I don't get dressed, wash w/difficulty, stay in bed.

30. Lifting:

- ☐ 0 I can lift heavy weight w/o extra pain.
- ☐ 1 I can lift heavy weight but it gives extra pain.
- ☐ 2 Pain prevents me from lifting heavy weights but I can manage if they are conveniently positioned.
- ☐ 3 Pain prevents lifting heavy weights but I can manage medium conveniently positioned weights.
- ☐ 4 I can only lift very light weights.
- ☐ 5 I cannot lift or carry anything at all.

40. Walking:

- ☐ 0 Pain does not prevent me walking any distance.
- ☐ 1 Pain prevents me from walking more than one mile.
- ☐ 2 Pain prevents me from walking more than ½ mile.
- ☐ 3 Pain prevents me from walking more than ¼ mile.
- ☐ 4 I can only walk using a cane or crutches.
- ☐ 5 I am in bed most of the time and crawl to the toilet.

50. Sitting:

- ☐ 0 I can sit in any chair as long as I like.
- ☐ 1 I can only sit in my favorite chair as long as I like.
- ☐ 2 Pain prevents me from sitting for more than 1 hour.
- ☐ 3 Pain prevents me from sitting for more than ½ hour.
- ☐ 4 Pain prevents me from sitting more than 10 min.
- ☐ 5 I avoid sitting as it increases my pain straight away.

60. Standing:

- ☐ 0 I can stand as long as I want w/o extra pain.
- ☐ 1 I can stand as long as I want but w/ extra pain.
- ☐ 2 Pain prevents standing for more than 1 hour.
- ☐ 3 Pain prevents standing for more than ½ hour.
- ☐ 4 Pain prevents standing for more than 10 min.
- ☐ 5 Pain prevents me from standing at all.

70. Sleeping:

- ☐ 0 I have no trouble sleeping.
- ☐ 1 I can only sleep well by taking medications.
- ☐ 2 I get less than 6 hrs before the pain wakes me.
- ☐ 3 I get less than 4 hrs before the pain wakes me.
- ☐ 4 I get less than 2 hrs before the pain wakes me .
- ☐ 5 Pain prevents me from sleeping at all.

80. Changing Degree of Pain:

- ☐ 0 My pain is decreasing and I am getting better.
- ☐ 1 My pain fluctuates but I am getting better.
- ☐ 2 My pain is decreasing; improvement is slow.
- ☐ 3 My pain is not changing – not better or worse.
- ☐ 4 My pain is increasing; gradually getting worse.
- ☐ 5 My pain is rapidly increasing – getting worse.

90. Social Life:

- ☐ 0 My Social life is normal and no extra pain.
- ☐ 1 My Social life is normal but increases pain.
- ☐ 2 Pain has no significant effect on my social life apart from limiting more energetic interests.
- ☐ 3 Pain restricts my social life; I don't go out often.
- ☐ 4 Pain has restricted my social life to my home.
- ☐ 5 I have no social life because of pain.

100. Pain Intensity:

- ☐ 0 I can travel anywhere w/o extra pain.
- ☐ 1 I can travel anywhere but with extra pain.
- ☐ 2 Pain is bad but I can take journeys over 2 hrs.
- ☐ 3 Pain restricts me to journeys less than 1 hr.
- ☐ 4 Pain restricts me to short journeys under ½ hr.
- ☐ 5 Pain prevents travel, except to my doctor.

Patient Signature: _____

Provider Name: _____ Signature: _____

Roland – Morris
Back Pain and Disability Questionnaire

Barcode #:

Name: _____ Today's Date: _____

Please read instructions:
When your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences that describe you today.

[ ] I stay at home most of the time because of my back.
[ ] I change position frequently to try to get my back comfortable.
[ ] I walk more slowly than usual because of my back.
[ ] Because of my back, I am not doing any jobs that I usually do around the house.
[ ] Because of my back, I use a handrail to get upstairs.
[ ] Because of my back, I lie down to rest more often.
[ ] Because of my back, I have to hold on to something to get out of an easy chair.
[ ] Because of my back, I try to get other people to do things for me.
[ ] I get dressed more slowly than usual because of my back.
[ ] I only stand up for short periods of time because of my back.
[ ] Because of my back, I try not to bend or kneel down.
[ ] I find it difficult to get out of a chair because of my back.
[ ] My back is painful almost all of the time.
[ ] I find it difficult to turn over in bed because of my back.
[ ] My appetite is not very good because of my back.
[ ] I have trouble putting on my sock (or stockings) because of the pain in my back.
[ ] I can only walk short distances because of my back pain.
[ ] I sleep less well because of my back.
[ ] Because of my back pain, I get dressed with the help of someone else.
[ ] I sit down for most of the day because of my back.
[ ] I avoid heavy jobs around the house because of my back.
[ ] Because of back pain, I am more irritable and bad tempered with people than usual.
[ ] Because of my back, I go upstairs more slowly than usual.
[ ] I stay in bed most of the time because of my back.

_____ _____
(Your Signature) (Date)

For Office Use Only:

Score: _____ Improvement: _____ %

Provider Name: _____ Signature: _____

MILLER CHIROPRACTIC

Dr. Michael A. Miller, DC, CCSP, PC
Dr. Adam Z. Miller, DC

Patient Intake Form

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible _____(patient name) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic service may be performed by the Physician Miller Chiropractic Offices and/or licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Michael Miller and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedures which the physician feels are in the best interest at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

Print Patient's Name	Print Name of Representative (e.g. if the patient is a minor) (Or is incapable of signing on their own)
Signature of Patient	Signature of Representative
Date: _____	Date: _____
Physician's Signature	Date:

CHIROPRACTIC OFFICES OF DR. MICHAEL A. MILLER, D.C., P.C.
884 Washington Street
Norwood, Massachusetts 02062

781-762-5600

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Dr. Michael A. Miller, D.C., P.C. or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____ _____
Patient or Legally Authorized Individual Signature — Date

_____ _____
Print Patient's Full Name — Time

_____ _____
Witness Signature — Date

Patient Intake Information **Date: _____**

(Legal) First Name_____(Legal)MI_____(Legal)Last Name_____DOB_____

Language: _____English _____Spanish _____Indian _____Japanese _____Chinese

_____Korean _____French _____German _____Russian _____Other

Race/Ethnicity: _____White _____American Indian/Alaska Native _____Asian _____Native Hawaiian/Other Pacific Islander _____Black or African American _____Hispanic or Latino _____Decline to Answer

Patient History: Please give a brief description of the problem(s) you are experiencing:

_____

_____

Is/Are the problem(s) getting better? ( ) Y/( ) N or getting worse?: ( ) Y /( ) N

When did the problems start? _____

What appears to be the initial cause: _____

Past History:

Have you: **If yes, please list the date & name of treating provider:**

Ever been diagnosed with hypertension? ( ) Y ( ) N _____

Been hospitalized in the last 5 years? ( ) Y ( ) N (Reason)_____

Been diagnosed with Diabetes? ( ) Y ( ) N _____

Type 1 ____ Type 2 ____ Do you smoke? ____Never ____Former ____Current

Vitals: Height: _____' _____" Weight_____lbs. Blood Pressure: _____/_____ Pulse:_____

Medications: What medications are you currently taking? Please include all non-prescription and over the counter vitamins, herbs, minerals, etc: List date started, Brand Name, Strength, Dosage, Frequency, Duration, Quantity, Refills Available, Prescribed by: PLEASE BE AS SPECIFIC AS POSSIBLE:

_____

_____

_____

Allergies: ( ) Food ( ) Environmental ( ) Medication

List type of Allergy and Reaction(s):

_____

_____