WELCOME TO THE WELLNESS CENTER OF CHESTER COUNTY, LLC

Patient Information

Name ____
First Name Last Name

Address ____

City ____________________ State ______ Zip ______________

Date of Birth ___________________________ Age ___________

Occupation: ____

Is your condition related to:

Employment: Date: __________ Claim? Y / N

Auto Accident: Date: ______State: ______Claim? Y / N

Personal Injury: Date: __________ Claim? Y / N

Contact Information

Home Phone: ____

Cell Phone: ____

Work Phone: ____

E-Mail: ____

Emergency Contact Info

Name: ________________________ Relation: ______________

Contact Number: ______________________________________

Insurance Information

Carrier: ____

Primary on this account: _______________________________

Primary's Date of Birth: _______________________________

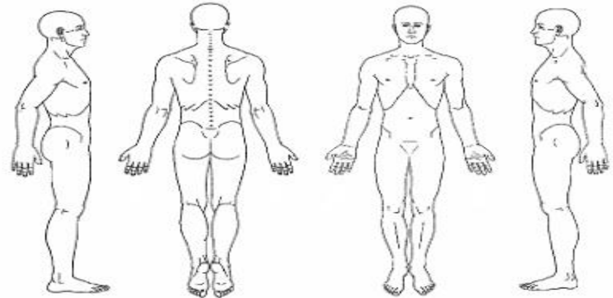
Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the above named carrier and assign directly to The Wellness Center of Chester County LLC 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 authorize the use of my signature on all insurance submissions and payment plans.

The Wellness Center of Chester County LLC may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining Insurance benefits or the benefits payable for related services. This consent will end when my care at The Wellness Center of Chester County has discontinued.

X ____________________________________ __________
Signature of Primary Date

Mark the areas of concern on the diagram below:



Average Intensity: Please Mark an X on the Scale Below

LEAST | _______________________________________ | WORST
1 2 3 4 5 6 7 8 9 10

HOW HAVE YOU TRIED TO SOLVE THIS PROBLEM?

- ☐ Medications
- ☐ Surgery
- ☐ Physical Therapy
- ☐ Chiropractic
- ☐ Stretching
- ☐ Ice
- ☐ Heat
- ☐ Massage

WHEN WAS YOUR LAST:

Physical: _______ X-Ray: _________ MRI: ___________

PLEASE MARK ALL THAT APPLY:

- ☐ Allergies
- ☐ Arthritis
- ☐ Carpal Tunnel
- ☐ Constipation
- ☐ Degeneration
- ☐ Fatigue
- ☐ Herniated Discs
- ☐ Headaches
- ☐ Kidney Problems
- ☐ Menstrual Problems
- ☐ Sinus Pain
- ☐ Thyroid Problem
- ☐ Tumors/Growths
- ☐ Asthma
- ☐ Bladder Problems
- ☐ Congestion
- ☐ Clenching
- ☐ Digestive Problems
- ☐ Gallbladder Issues
- ☐ High Blood Pressure
- ☐ Irritable Bowel
- ☐ Liver Problems
- ☐ Osteoporosis
- ☐ Stomach Problems
- ☐ TMJ Pain
- ☐ Visual Problems
- ☐ Other: ______________________________

Medications: _______________________________________

____

____

Allergies: ____

____

Stressful Environment? Y / N

- ☐ Falls: ______________________________
- ☐ Head Injuries: ______________________________
- ☐ Broken Bones: ______________________________
- ☐ Dislocations: ______________________________
- ☐ Surgeries: ______________________________
- ☐ Other: ______________________________

WELCOME TO THE WELLNESS CENTER OF CHESTER COUNTY, LLC

HIPAA ACKNOWLEDGEMENT FORM:

Notice of Privacy Practices

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have been provided:

The Wellness Center of Chester County, LLC's (WCCC) Notice of Private Practices (NPP).

- It tells me how WCCC will use my health information for the purposes of treatment, payment of treatment, and WCCC's health care operations
- NPP explains in detail how the WCCC may use and share my health information for other than treatment, payment, and health care options
- WCCC will also use and share my health information as only required and/or permitted by law
- I consent to the WCCC using and disclosing my treatment for the purposes detailed in the NPP.

X ____

Patient/Guardian Signature Date

INFORMED CONSENT:

Please Read Carefully

I understand that there are beneficial effects associated with these treatments procedures including decreased intensity of pain, improved mobility, improved function, reduced frequency of occurrence in symptomatology, and lower duration of experienced symptoms. I also understand that my condition may worsen and referral may be necessary if a course of Chiropractic care does not help or improve my condition.

Reasonable alternatives to the procedures provided at this office have been explained to me including prescription medications, over-the-counter medications, surgical options, and non-treatment. Risk of these alternatives have also been explained to me. I have read the previous information regarding risks of Chiropractic care and my doctor has verbally explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to these options. All of my questions have been adequately answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.

X ____

PATIENT [or PARENT/GUARDIAN] SIGNATURE DATE

____

DOCTOR SIGNATURE DATE

DOCTOR'S NOTES

IDC-10 Codes

Spinal Codes
M9900 - Occiput
M9901 - Cervical
M9902 - Thoracic
M9903 - Lumbar
M9904 - Sacral
M9905 - Pelvic

Extremity Codes
M9906 – Lower Ext
M9907 – Upper Ext
M9908 – Rib Cage

Pain Codes
M542 - Cervical
M545 – Low Back Pain
M546 – Pain In Thoracic Spine

Radiculopathy Codes
M5411 - Occiput
M5412 – Cervical
M5413 – Cericothoracic
M5414 – Thoracic
M5415 – Thoracolumbar
M5416 – Lumbar
M5417 – Lumbosacral
M5418 – Sacral
M5430 – Sciatica unspe
M5431 – Sciatica left
M5432 – Sciatica right
M5440 – Lumbago w sciatica unspec
M5441 – Lumbago w sciatica left
M5442 – Lumbago w sciatica right
R519 – Headaches, unspecified
R510 - Headaches with orthostatic component

CPT Codes
98940 – 1 – 2 Regions
98941 – 3 – 4 Regions
98942 – 5 Regions
98943 – Extra Spinal
97110 – Strength/ROM
97112 – Neuromuscular Re-Education
97116 – Gait Training
97124 – Manual Therapy
97140 – Manual Traction
97530 – Soft Tissue/Activity
97535 – Home Care Instructions

Total # of Visits: _____ Chiro ____x/week/month
_____ Massage ____ x/week/month
_____ Exercise ____ x/week/month
_____ Corrective ____ x/week/month
_____ Nutrition ____ x/week/month